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The Development of an Effective Treatment Program for Schizophrenics

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THE DEVELOPMENT
OF AN
EFFECTIVE TREATMENT PROGRAM
FOR
SCHIZOPHRENICS

By

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"Though this be madness,
Yet there is method in it."

Wm. Shakespeare,
"Hamlet"

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PREFACE

I have long been fascinated by the field of psychopathology; particularly the various therapies devised to deal with schizophrenia. While working with schizophrenic patients for three years as a Social Group Worker at Saint John's Hospital, Santa Monica, California, I noticed that many patients were released and then subsequently readmitted repeatedly. I developed a desire to know what sort of program was actually most effective in treating this disorder, and further, what qualities a therapist must have to form a truly effective therapeutic relationship with schizophrenic patients.

My experience in this field, which has proven valuable to me professionally and personally, consists of helping to plan a socialization and recreational program for Inpatients and Day Treatment patients, and leading a variety of therapeutic groups. Although these experiences were gained under supervision, much of what I learned was by "trial and error." In the beginning, I felt very much like many of the patients - frightened and inexperienced, but nevertheless perceptive to what was happening around me. In time, I developed insight into the fantasy worlds of my patients and learned to understand, at an intuitive level, how to relate to them in a way that could best benefit them whether as individuals or in a group setting. Primarily, I found that an attitude of openness toward them garnered a rare

type of trust, and from this I was able to obtain very satisfactory results. This enhanced my own sense of self-worth and professional satisfaction.

I have not been active in this treatment field for more than four years, and now work as a counselor at the South Bay Center for Counseling, dealing with a less disturbed population. In my view, this suspension of personal involvement has afforded me a more objective standpoint, permitting me to appreciate the evident need to ascertain which existing therapeutic interventions have proven most effective and what more can be done. I have attempted to evaluate such treatments by studying the pertinent body of literature, and particularly exploring existing Day Treatment programs by personal contact.

I trust that this thesis will be of some use for therapists working with a schizophrenic patient population and that it will facilitate the development of more effective therapeutic relationships and treatment programs.

At the outset, I would like to offer my sincere thanks to those people who were of help in making this project possible; the Directors of the four treatment facilities I visited: Jan Matsutsuyu and the Neuropsychiatric Institute Adult Development Group; Terry Larson and Saint John's Hospital Adult Day Treatment Center; Ann Kennedy and David Brotman Memorial Hospital Psychiatric Unit; and Terry McBride and Di Di Hirsch Community Adult Day Center. I would also like to extend my appreciation

to those therapists who responded to my questionnaire poll. Finally, I want to acknowledge my gratitude for the encouragement and support of my Faculty Sponsor, Alan Brown, M.D., my Faculty Administrator, Peggy McAllister, Ph.D., my Outside Reader, Frank Hull, Ph.D., and my Peer Reader, Andrea Schalman. To my friends, family and colleagues, I extend my very warmest thanks for your confidence in me and for being there when I needed your help, encouragement and criticism.

I. NEEDS ASSESSMENT

INTRODUCTION

Schizophrenia has been studied from every possible aspect, in search of a cause and a cure. No research has conclusively sustained any single etiological theory, cure or method of intervention. It appears to me that practicality dictates that the present goal should be limited to development of an effective treatment intervention.

Herein, I intend to develop a prototype treatment program for schizophrenics and to determine whether such a program is needed or might be utilized and effective in the Los Angeles metropolitan area. I will assess the need for such a program by means of visits to local treatment facilities and interviews with the program directors concerning the program structure and the clinical emphasis. I have devised a questionnaire, included in the Appendix, for therapists involved in these programs. The questionnaire will rate those qualities in a therapist and those treatment methods and modalities which are considered by the responding therapists to be most and least effective in the treatment of schizophrenics.

The nature of the schizophrenic disorder, involving disturbances of thinking, mood and behavior, makes it inherently difficult to establish an effective therapeutic relationship. Since the formation of an effective relationship is necessary

for a treatment program to be workable, an understanding of the disorder is a prerequisite for an effective therapist. Toward that end, I shall present a brief overview of the schizophrenic syndrome and append a portion of a previous paper which I authored about etiological studies. Thereafter, I shall set forth the main psychiatric models now utilized in approaching treatment methods.

The next areas of discussion will be those qualities in a therapist and treatment methods and modalities which have evinced effectiveness in the treatment of schizophrenia. I shall then assess the results of my questionnaire and the significance of the data and my personal observations with respect to the facilities I visited.

Next, I will introduce the various therapies which will be integrated and developed into a proposed treatment program. To reiterate, my conclusion will determine whether the schizophrenic treatment program I have developed is needed, or might be utilized and effective, based upon existing research and information.

SCOPE AND LIMIT

The scope of this study will include the development of a model treatment program for schizophrenics and determination, on the basis of literature and visits to and questionnaire distributed to existing treatment facilities, whether such a program is needed, or might be utilized and effective in the treatment of schizophrenics.

Visits to treatment facilities will be limited to four Adult Day Treatment Centers. Of course, questionnaires will be distributed only to those facilities which permit such disclosure. Those therapists polled will currently be treating a schizophrenic patient population. Of necessity, only those questionnaires which are timely returned will be represented herein. The data will be summarized in terms of "most" and "least" effectiveness as determined by the responding therapists. Furthermore, I shall use the word "patient" in referring to schizophrenics, rather than the term "client," which commonly refers to individuals functioning at a higher level (Carkhuff, 1967).

The present thesis is limited to having therapists who work with schizophrenics determine which qualities in a therapist they consider the most and least effective. A future project could well benefit from distribution of this questionnaire among the schizophrenic patients themselves, as they oftentimes are the best judges of the attitudinal qualities of the relationship than even the therapists (Rogers, 1967).

OVERVIEW OF THE SCHIZOPHRENIC SYNDROME

Since, in my view, an awareness of the schizophrenic syndrome is a predicate to appreciating the various approaches and models in the development of a treatment program, a brief overview may be helpful.

Schizophrenia has been described variously throughout the last century, as indicated by the following historical progression:

1849 - John Conolly described it as an affliction of young people that resembled melancholy.

1860 - Benedict Morel felt it represented depression and withdrawal in adolescent youth; spoke of a transition into a condition of dementia praecox.

1896 - Emil Kraepelin described dementia praecox and brought together previously described catatonic, hebephrenic and paranoid states. The disorder was thought to be a disease of the brain with unknown origins.

1906 - Adolf Meyer thought it represented the organism's difficulty in adapting itself to the demands of the environment. Fantasy substituted increasingly for goal-directed behavior and ineffective unduly complicated forms of behavior were elaborate.

1911 - Eugen Bleuler, who coined the term "schizophrenia," thought it was a group of behavior patterns reflecting the interaction of psychological stresses with an underlying genetic fault. The outcome often was a devolution of the total personality, and he believed that treatment did not bring about a full restitution of good health.

1939 - Sigmund Freud believed it was a regression or turning away from external relationships to an earlier condition of narcissism in which the ego was poorly differentiated.

(Will, 1975)

Today's prevailing definition of schizophrenia entails the concept of a group of disorders characterized by disturbances of thinking, mood and behavior, which may have secondary symptoms of hallucination, illusion and delusion (Sadock, 1975-b). In the *Comprehensive Textbook of Psychiatry*, schizophrenia is defined as a mental disorder of a psychotic level, formerly known as dementia praecox, of unknown cause. The thinking disturbance is manifested by a distortion of reality, accompanied by a fragmentation of associations which may result in incoherent speech. The mood disturbance is manifested by inappropriate affective responses to specific situations. The behavioral disturbance is manifested by ambivalence, apathetic withdrawal and bizarre activity (Freedman, Kaplan and Sakock, ed's., 1975).

Schizophrenia is often characterized by the four primary symptoms which Bleuler reported to find together in no other condition. These symptoms, referred to by some as the "4 A's," are disturbances in associations, affect, ambivalence and autism as depicted in the schizophrenic disorder. Disturbance in association, known also as schizophrenic thought disorder, refers to the tendency of irrelevant features of a total concept to cue associations which interfere with logical pointed thinking. This type of association is often confused, bizarre, vague, incorrect and incomprehensible because of the jumble of irrelevant associations characterizing it. Disturbances in

affect or emotional response may be either a lack of emotional response (referred to as "flat affect"), or a completely inconsistent emotional response to a thought or action (referred to as an "inappropriate response"). Ambivalence is the virtually simultaneous conscious occurrence of opposing thoughts, emotions or impulses. Autism is the word coined by Bleuler representing a tendency to withdraw from involvement with reality and become preoccupied with illogical, egocentric ideas, fantasies and distortions (Lauler, 1971).

Some later workers have continued to expand the concept to include cases that neither Kraepelin or Bleuler would have considered schizophrenic. For example, patients are now classified as "schizophrenic, schizoaffective types" when the clinical picture includes features associated with manic-depressive illness as well as schizophrenia. In addition, there are some clinicians who include cases that others would still classify as severe neuroses or personality disorders. Such patients are often referred to as "borderline schizophrenics" and are classified officially, along with other patients who have never displayed any secondary symptoms, as "latent type" schizophrenics (Lauler, 1970).

TREATMENT MODELS

The psychiatric models discussed herein represent a perspective or viewpoint of the cause of this disorder and are the basis from which are derived the treatment methods and modalities. There are similarities among many of these models in their approach to schizophrenia. The basic difference, as I conceive it, is the view of schizophrenia as having either conscious or unconscious origins. I believe that the model followed is far less important to effective treatment than the display of facilitative therapist qualities. The next section of this thesis deals with such qualities as well as those treatment methods and modalities determined to be most effective, but for now, I shall concentrate on the five psychosocial models.

All of these models take some cognizance of social influences as well as of internal psychological processes, and best approximate the approach advocated by Philip May as effective in the treatment of schizophrenia. These models follow a strategy of successive approximations and can be readily modified or abandoned if necessary to accommodate new evidence (Coleman, 1976). The five psychosocial models are mutually complementary, despite their representation of distinct and sometimes conflicting orientations.

The Psychosocial Models

Psychoanalytic Model

The psychoanalytic model is premised upon the person's domination by instinctual biological drives, as well as by unconscious desires and motives (Coleman, 1976). This model holds psychopathology to be the defects, lacks or difficulties incurred in the course of an individual's development (Will, 1975). Thus, the psychoanalytic model appears to involve a negativistic and deterministic view of human behavior that minimizes rationality and freedom for self-determination (Coleman, 1976). Additionally, it appears to emphasize an undue pessimism about basic human nature, an exaggerated role of unconscious process, and in my opinion, it fails to consider motives toward personal growth.

Psychoanalytically-oriented therapy concerns understanding the psychodynamics of the patient (Loew, 1975), imbuing the treatment with the influence of the therapist's preconcieved notions more than the patient's discoveries (Carkhuff, 1967). Therapists utilizing this model may advocate patients reenacting either in action or in fantasy, the infantile situation in order to gratify their originally frustrated needs (May, 1975-b). Or, as in another approach, a psychoanalytically-oriented therapist may attempt to interpret the schizophrenic's defenses and focus on reality rather than on unconscious content (May, 1975-b).

However, due to this extremely insight-oriented approach to schizophrenia, I do not consider this model applicable to treatment as this type of patient is, in my opinion, most often not at the necessary level of awareness.

Behavioral Model

The behavioral model is constructed upon the concept of behavior in response to specific stimuli. The focus of therapy is on changing specific behaviors with the elimination of undesirable ones and the learning of desirable ones (Coleman, 1976). The therapist adhering to this model identifies pertinent stimuli, specifies the behavior to be changed, defines concrete goals in terms of precise changes in behavior and decides on the learning principles to be used (Coleman, 1976). Thus, behavioral therapists concentrate upon the "shaping" of behavior in a didactic, therapeutic process (Carkhuff, 1967).

This model views the maladjusted person as having learned faulty coping patterns which are maintained by some kind of reinforcement, and/or having failed to acquire needed competencies for coping with problems (Coleman, 1976). In contrast to the psychoanalytic model, which explores inner conflicts and attempts cognitive change, behavioral therapists thus attempt to modify behavior more directly (Coleman, 1976).

This approach, while well disposed to the conduct of precise and objective research, fails to include subjective experiences and related causal factors in the therapy. The behavior model,

with its focus on stimulus-response situations and observable behavior, can be seen as an oversimplification which neglects the psychological make-up, inner experiences and potential for self-direction of the individuals (Coleman, 1976). However, bringing the desired responses under the control and self-monitoring of the patients, I believe, is most desirable in treating schizophrenia.

Humanistic Model

The humanistic model views basic nature as good and similarly to the behavioral model, places strong emphasis on inherent capacity for responsible self-direction. Pursuant to this theory, psychopathology is the distortion and blocking of personal growth, and is the result of a variety of causal factors, including the exaggerated use of ego mechanisms, unfavorable social conditions, faulty learning and excessive stress (Coleman, 1976). Thus, the humanistic model is similar to those models previously discussed in some of their causal theories, and also focuses on helping individuals in dropping their defenses, acknowledging their experiences, percieving themselves realistically, achieving needed competencies and increasing their capabilities for personal choice, growth and fulfillment (Coleman, 1976).

The humanistic model is like the psychoanalytic model with respect to the concern with stress situations involving a threat to the individual, eliciting anxiety, and the use of ego-defense

mechanisms (Coleman, 1976). However, unlike the psychoanalytic model, humanists do not use much past interpretation, but instead stress the here-and-now. Further, as in the existential model (to be discussed), the humanistic model believes that blocked or distorted personal growth is the primary cause of psychopathology, and also focuses on problems relating to values, meaning and personal growth. In contrast to the behavioral and psychoanalytic models which view behavior as being determined by forces beyond control (Coleman, 1976), I prefer the more positive view of human nature and potential as expounded by those therapists incorporating the humanistic model.

Existential Model

The existential model is less clearly defined than the others, but seems to have gained a degree of acceptance. The emphasis is on the uniqueness and totality of an individual's existence, and recognition is given to one's values, mode of being in the world and religious qualities (Will, 1975). This model is akin to the humanistic one, but represents a less optimistic viewpoint, with emphasis on the irrational tendencies of individuals in a dehumanizing mass society (Coleman, 1976). Similarities exist in the assumption of a capacity for responsibility and rational choice.

This model views psychopathology as the result of existential anxiety caused by alienation and estrangement (Coleman, 1976), and focuses on the crucial questions concerning the nature

of man (Carkhuff, 1976). Thus, the thrust of therapy following this model is on helping individuals clarify their basic values and working out a meaningful existence in society. As in the other models discussed, there are similarities in approach. However, the major difference as I see it, is the emphasis on the problems of the individual in relating to the demands of society and finding a meaningful existence in it.

Interpersonal Model

There has been no systematic model of human nature and behavior based entirely on interpersonal relationships or the social context in which we function (Coleman, 1976). The closest approximation appears to be the interpersonal view developed by Harry Stack Sullivan, which places a strong emphasis on unsatisfactory interpersonal relationships as the primary causal factor in many forms of maladaptive behavior. The focus is on the alleviation of current pathogenic relationships and on helping the individual achieve more satisfactory ones. Therapy in this model would concern itself with verbal and nonverbal communication, social roles, process of accommodation and a general interpersonal context of behavior (Coleman, 1976).

As in the psychoanalytic model, I postulate that a strong emphasis would also be placed on the use of the therapeutic relationships itself as a vehicle for learning new interpersonal skills. Focusing on problems within the patient's family system and its distorted thought and communication process would also be emphasized in the interpersonal model (Will, 1975).

The Medical Model

As opposed to the five psychosocial models discussed, the medical model looks at psychiatric disorders as diseases comprehensible in terms of etiology, pathology, course, prognosis, epidemiology and treatment (Will, 1975). This model encompasses the original view of mental illness. It differs from the psychoanalytic model, which views psychopathology as defects in instinctual drives, as the medical model views mental illness in the same terms as physical illness. Thus, following the medical model, the search would be for the organic causes, cures and prevention of illness (Coleman, 1976).

Having discussed the five basic psychosocial models and the medical model, I should state my belief that a combination of these viewpoints is necessary to treat this very complicated and multisymptomatic schizophrenic disorder. For this purpose, I would like now to present the eclectic model as a combination of elements from each of the foregoing approaches into a comprehensive and open model from which to derive a treatment.

The Eclectic Model

I propose the use of an eclectic model for the treatment of schizophrenia. In so doing, I employ a concept introduced by Carkhuff and Berenson in their book, *Beyond Counseling and Therapy*, in which they describe the eclectic model as being open, yet systematic, built around a central core of conditions and complemented by the unique contributions of a variety of potential

preferred modes of treatment. This model centers on the commitment of the whole counselor and

> "leads him to know all that is knowable so that he can fully discharge his responsibility to his client as well as to himself, ...and he turns to existing bodies of knowledge in order to determine for himself the contributions of each." (Carkhuff, pg.61, 1967)

Thus, this eclectic model involves the therapist being shaped by what is effective for the client, and both being shaped by what is effective for themselves and others. I advocate the approach suggested by Carkhuff and Berenson because, in their words, it is

> "...the first approach that emphasizes a process culminating in a moment-to-moment, fully sharing process -- a process born not only of the emotional resources of both parties to the relationship, but also of the deepest and broadest understanding of existing knowledge, and complemented by anything that will work for the client." (Carkhuff, pg.233., 1967)

I believe that a working knowledge of all models is therefore useful and should be applied as appropriate in the treatment of schizophrenia. I am somewhat partial to the employment of the behavioral model, since I believe that therapy needs to be translated into action and

> "all therapists should serve to alter the overt real-life behavior of their client." (Carkhuff, pg.83., 1967)

However, I also accept the application of the interpersonal model to help patients develop satisfactory relationships, the humanistic model to provide patients an impetus to choosing growth and fulfillment and the taking of responsibility for these choices, the existential model to help patients clarify their

own individual values and find their own meaning in life, and the medical model to provide essential drug therapy.

Whatever model or combination of models is utilized, I believe that the therapist needs to display facilitative qualities of effectiveness. The major difference between the various models seems to be the view of schizophrenia as being of either conscious or unconscious origins. I shall discuss the various therapies derived from these models in the section covering therapeutic modalities for an effective treatment program.

EFFECTIVE THERAPIST QUALITIES

I believe that therapists working with schizophrenics must acutely realize their importance in their patients' world, as well as their utmost importance in the therapeutic relationship, itself. *Estrangement & Relationship - Experience with Schizophrenics*, Francis Macnab, helped me to crystallize this concept by stating:

> "In work of this kind there is a tendency to talk too much about the patients and say very little about the therapist. So often our attention is directed toward our experiences of the patient and in doing so, we tend to neglect the patient's experience of us." (Macnab, 1965)

I fully agree with this concept and am keenly aware of my need to know what qualities are in fact important in this work.

I shall first cover the qualities in a therapist which Carkhuff and Berenson in their research for *Beyond Counseling and Therapy* determined to be effective. I shall incorporate these data in designing the first part of my questionnaire (Appendix) to evaluate therapists' opinions of the various therapeutic qualities which they believe are the most and least effective in dealing with a schizophrenic patient population. I consider the qualities possessed by effective therapists to be far more important than the treatment model they follow.

Robert Carkhuff and Bernard Berenson, on the basis of their studies, hold that there is extensive evidence indicating that the facilitative or retarding effects of a psychotherapeutic relationship can be accounted for by a core of dimensions which

are shared by all interactive human processes, independent of theoretical orientation (Carkhuff and Berenson, 1967). They present a model for the primary qualities necessary in an effective therapist, consisting of facilitative communication of the core dimensions of empathy, respect, genuineness and concreteness. Additional dimensions such as the levels of appropriate self-disclosure, spontaneity, intensity, confidence, openness, commitment and flexibility have also been postulated, but empirical data in support of these dimensions is sparse (Carkhuff, et al, 1967).

Carkhuff and Berenson express the idea of empathy in this context:

> "The therapist's ability to communicate at high levels of empathic understanding appears to involve the therapist's ability to allow himself to experience or merge in the experience of the client, reflect upon this experience while suspending his own judgments, tolerating his own anxiety, and communicating this understanding to his client." (Carkhuff, et al, 1967)

It appears, then, that the manner of the therapist, rather than theory or technique, is what communicates understanding and fosters growth. In the treatment of schizophrenics, even the intent to understand can itself be of value (Rogers, 1975). I speculate that even the realization that a therapist is trying to understand the bizarre, uncertain and confused statements of many schizophrenics, would in itself encourage further communication and help the patient recognize that even atypical communication is perceived as being worthy of understanding by the therapist.

The therapist's respect or positive regard for the patient may be communicated via the therapist's introduction of human warmth and understanding into the therapeutic relationship. This necessitates the therapist's commitment and effort to understand and communicate the most sincere respect for the patient's worth and potential as a free individual (Carkhuff, 1967). This manifestation of caring must be independent of judgmental reactions to the patient's thoughts, feelings or behavior. An apt depiction of this type of caring was made by Carl Rogers in *The Therapeutic Relationship and Its Impact: A Study of Psychotherapy in Schizophrenia*:

> "The therapist prizes the client as a parent prizes his child; not because he approves of every expression or behavior, but because his caring is total rather than conditional." (Rogers, et al, 1967)

This attitude would hopefully lead to trust, further self-exploration and the correction of false statements as therapy progresses and trust deepens.

Concreteness or specificity of expression is described by Carkhuff and Berenson as

> "...a variable which is largely under the therapist's direct control involves the fluent, direct and complete expression of specific feelings and experiences, regardless of their emotional content, by both therapist and client." (Carkhuff, 1967)

Concreteness ensures that the therapist's response does not become too far removed from the patient's feelings and experiences, and encourages the therapist to become more accurate in achieving an understanding of the patient. Thus, the patient is directly influenced to attend specifically to problem areas and emotional conflicts.

Genuineness is based on the degree to which the therapist can be true-to-self and therefore honest with the client or patient. It is the distinction between how a therapist communicates and how much of the therapist's own personality is revealed by what is said. Genuineness and congruence are the most basic of the attitudinal conditions which foster therapeutic growth, according to the studies of Rogers as well as Carkhuff and Berenson. This core dimension clearly involves self-awareness on the part of the therapist, so that personal feelings and experiences are available, and to make possible spontaneous interaction in the therapeutic relationship.

Rogers determined on the basis of his studies, that patients receiving the most accurate empathy from the therapist showed the greatest reduction in schizophrenic pathology. His follow-up study of those schizophrenics, conducted nine years later, showed that those who felt they had received high levels of empathy, positive regard and genuineness in the therapeutic relationship had a distinctively better follow-up history. Those patients were able to stay out of psychiatric hospitals much longer than the ones whose therapeutic relationship was marked by low levels of these conditions (Rogers, 1967).

To me, these studies indicate that to be effective, a therapist needs to display high levels of the core facilitative qualities of empathy, genuineness, positive regard and concreteness. Additionally, these attitudes need to be effectively communicated to and perceived by their patients.

In my own therapeutic work with schizophrenics, I found that these patients, due to their astuteness and perception, were quite aware of exactly which attitudes I was conveying, and whether my expression of concern was genuine. Having this knowledge, I always asked for feedback at the end of group sessions and was open to criticism of my therapeutic effectiveness.

EFFECTIVE TREATMENT METHODS AND MODALITIES

I believe that therapists working with a schizophrenic patient population need also to be aware of which treatment methods and modalities have been demonstrated to be the most effective. For this reason, I shall next present Philip May's evaluation of the treatment methods proven to be most effective with schizophrenics. I shall incorporate this research in devising and evaluating the second section of my questionnaire (Appendix), asking those therapists polled to determine which methods and modalities they consider most and least effective in their work with schizophrenic patients. Additionally, I will utilize results from the questionnaire in the planning of an effective treatment program.

May's review and evaluation of controlled studies of treatment approaches to schizophrenia was based on the suggestion that effective treatment of schizophrenia would produce freedom from unusual pain with at least a modicum of enjoyment in life and a degree of productivity and participation in society (May, 1975-a). May states in his respective articles, "Schizophrenia: Evaluation of Treatment Methods" (1975-a) and "Rational Treatment for an Irrational Disorder: What Does the Schizophrenic Patient Need?" (1976), that he selected studies for this review that had been published in recognized professional journals or books, and took into account the degree of confidence with which the findings could be applied to the

treatment of schizophrenia, as well as the quality of the experimental design and analysis of the results (May, 1976). May's evaluation studies covered the areas of Milieu care and Rehabilitation, Inpatient Psychotherapy, Outpatient Psychotherapy and Somatic Therapies.

May's research strongly supported the efficacy of pharmacotherapy, antipsychotic drugs in particular (May, 1975-a). The major tranquilizers or antipsychotic drugs have proven to be highly successful in calming psychotics who manifest emotional tension, disordered thought processes and motor hyperactivity (Coleman, 1976). According to May, drugs have their greatest use in restoring contact and establishing therapeutic relationships during the stage of florid psychosis and in maintaining perceptual control later in the stage of chronic and subacute illness (May, 1976). Once the patient is in better contact, with secondary symptoms such as delusions and hallucinations reduced, psychological and social methods can certainly be more effective. The use of antipsychotic drugs has made it possible for many schizophrenic patients to function in the community without hospitalization. It has also led to earlier discharge of those patients who did require hospitalization, as well as for obviating to a degree the need for locked wards and restraints. However, drugs as well as psychotherapy and psychosocial methods should play supplemental roles for effective treatment in schizophrenia (May, 1976).

According to May's evaluation, the greatest evidence pointed to the value of combining pharmacotherapy and Outpatient efforts to reduce residual disability after remission of acute psychosis and to develop social and occupational skills (May, 1976). The most successful form of Outpatient therapy was group therapy which focused on social and occupational rehabilitation along with an emphasis on problem solving. This orientation toward support and rehabilitation proved more effective than formal attempts (either in individual or group therapies) to promote insight and deeper psychological meaning.

Day Care or Home Care, when practical, was as good as or better than Inpatient Treatment, provided that drug treatment was adequate, according to May's studies. Inpatient Milieu programs (which emphasize appropriate sociocultural environmental manipulation for the benefit of the patients) produced good results, the most effective ones concentrating on real-life problems and on discharge planning. May concludes that there was adequate evidence that Aftercare Programs (after hospitalization, the continuing program of rehabilitation designed to reinforce the effects of therapy and to help the patient adjust to his environment) helped patients remain in the community after hospital discharge (May, 1976).

May's evaluation indicates that Inpatients treated with individual psychotherapy aimed at psychological understanding did not improve more than a control group, and group therapy that focused on reality or on a group activity was more effective than control or even group therapy which emphasized insight

(May, 1976). Therefore, therapy focusing on insight and psychological understanding is not shown to be effective with schizophrenics.

On an Outpatient basis, individual casework and rehabilitation was more effective than control; group therapy was more effective than control and group therapy was demonstrated to be more effective than individual therapy. Outpatient group therapy was most effective when emphasizing the problems and tasks of daily living in combination with maintenance drug treatment.

As previously stated, antipsychotic drug therapy did garner the greatest evidence of therapeutic effect. The evidence was negative for Nicotinic Acid (Megavitamin) therapy as well as Electroconvulsive therapy. Behavioral Conditioning was virtually untested by controlled studies at the time this review was made (May, 1975-a).

In summary, research indicates that a combination of drugs and psychosocial therapies is the most effective way to treat schizophrenia, with the most successful programs emphasizing problem solving, social adjustment, living arrangements, obtaining employment and facilitating cooperation with maintenance drug therapy. The most beneficial psychotherapy was group therapy focusing on social and occupational rehabilitation. A combination then, of pharmacotherapy with Outpatient Care, Day Care or Home Care would be most effective. Finally, as least conducive, combined with Inpatient Milieu programs, appears to be the treatment modalities of choice, according to May.

QUESTIONNAIRE ASSESSMENTS

I have devised a questionnaire (Appendix), based partially on Carkhuff and Berenson's research as well as May's results, to evaluate therapists' opinions of the effectiveness of therapist qualities and treatment methods and modalities in terms of what they consider to be the most and least effective in their work with schizophrenics. Questionnaires were distributed at three of the four facilities I visited and at two outside therapists' who currently work with schizophrenic patients. I also invited comments relating to innovative methods.

The response was disappointing. From two facilities I received a one-third response and from the other, no response at all. Fifteen questionnaires were left at Brotman Memorial Hospital and five were returned; two by psychiatric technicians, two by psychiatric nurses and one by a vocational counselor. Nine questionnaires were left at Di Di Hirsch Community Adult Center, but only three were returned; by two psychiatric social workers and one psychiatric technician. Seven questionnaires were distributed at the Neuropsychiatric Institute Adult Development Group, but none were returned. Saint John's Hospital Day Treatment Center would not allow disclosure and will not be represented in this poll. Questionnaires were also submitted to a psychiatrist and to a marriage and family counselor in private practice with schizophrenic patients, of whom each responded. In summary, there are represented three

psychiatric technicians, two psychiatric social workers, two psychiatric nurses, one vocational counselor, one psychiatrist and one marriage and family counselor in private practices.

Assessment Of Therapist Qualities

The results of my questionnaire showed that, according to those therapists polled, the most effective therapist qualities in working with a schizophrenic patient population are Positive Regard, Genuineness, Respect, Concreteness, Encouragement and Empathy.

Those qualities considered to be partially effective, in the order indicated by the poll, are Persistence, Flexibility, Firmness and Understanding.

Therapist qualities deemed to be the least effective in working with schizophrenics, according to the responses to my questionnaire, were Dedication, Tolerance, and finally, Self-Disclosure.

In the space provided for remarks, one therapist thought that Directness, Consistency and Confrontation/Reality Testing were also effective qualities in a therapist.

On the basis of my results (Tabulated Questionnaire in Appendix), it appears that the majority of the therapists polled do agree with Carkhuff and Berenson's results, i.e., Genuineness, Empathy, Respect (or Positive Regard) and Concreteness. I postulate that the quality of Encouragement was cited by the responding therapists because schizophrenic

patients often need encouragement to participate in the activity programs in which most of the therapists participate. Self-disclosure was rated as the least effective quality. To me, this could indicate the possibility of a diluted genuineness conveyed by these therapists.

In summary, the responses I received to this questionnaire suggest that the therapists polled advocate qualities in therapist effectiveness congruent with the studies published by Carkhuff and Berenson.

Assessment Of Treatment Methods and Modalities

The responding therapists considered a Day-Hospital Program to be the most effective treatment modality for the schizophrenic patient population. Antipsychotic Drug Therapy, Socialization Programs, Family Therapy and Group Therapy, respectively were rated as the next most effective methods and/or modalities. Those determined to be least conducive are, in order of ineffectiveness: Megavitamins, Psychosurgery, Laingian/Existialism Approach, Sensory Awareness Groups, Psychodrama, Electroconvulsive Therapy, and Psychoanalysis.

A complete tabulation rating the effectiveness of treatment methods and modalities is found in the Appendix. Those rated as partially effective include, in order of preference: Vocational Rehabilitation, Outpatient Therapy, Recreational Therapy, Occupational Therapy, Behavior Modification, Inpatient Milieu Program, Individual Therapy, Home Care, Eclectic Thera-

pies and Dance Therapy. Write-ins were Crisis Intervention and Aid to Daily Living as effective modalities.

Comparing these results with Philip May's results points up some discrepancies. For example, May considers a combination of pharmacotherapy and psychosocial therapies to be superior to psychotherapy and sociotherapy alone. Moreover, his evaluation determines drug therapy to be most effective and recommends pharmacotherapy (antipsychotic drugs) supplemented by, in order of effectiveness, Outpatient care focused on social and occupational rehabilitation, Day Care and Home Care when practical, and finally, Inpatient Milieu programs which concentrate on real life problems and discharge planning. According to May, Outpatient Care was shown to be four times as effective as Inpatient Care, when combined with antipsychotic drug therapy. Group Therapy, which focused on problem solving, social and occupational rehabilitation, was more conducive than Individual Therapy which aimed at psychological understanding (May, 1975-a).

Utilizing May's evaluation studies as a basis to evaluate my questionnaire, but without expecting exact replication, it is apparent that aspects of his criteria were definitely among those rated as most effective. Due to the complexities in many of the approaches May described, I found it necessary to be somewhat more categorical. For example, a Socialization Program could be part of both Inpatient and Day Hospital Programs, as could many of the other treatment methods and modal-

ities. Quite often, Day Treatment and Inpatient Programs are combined, as is the case at Brotman Memorial Hospital. For these reasons and also as an aid to the development of a model treatment program for schizophrenics, I determined the necessity to further break down treatment interventions than done by May. I initially had reservations about the number of treatment modalities I had included as choices in the questionnaire, as I intended designing a short and concise one that could be filled out rapidly by the therapists. However, I am presently aware of the need to further clarify some of the therapeutic interventions. For example, it would have simplified comparison with May's studies had I included types of therapeutic focuses with the treatment modalities; i.e., Group or Individual Therapies which focused on problem solving versus emphasis on psychological insight.

The results of this part of the questionnaire were fairly illuminative of the particular types of programs in which the therapists were involved. Thus, socialization programs, antipsychotic drug therapy and family and group therapies showed high ratings of effectiveness on my questionnaire tabulation and also were integral parts of all facility programs visited. Surprisingly, Outpatient therapy was rated relatively low in effectiveness, which may be due in part to the high proportion of responses from Brotman Memorial Hospital, which does not have an Outpatient therapy program. Inpatient Milieu programs, however, were determined by those same therapists to be less

effective than Outpatient therapy, which is not included at Brotman Memorial Hospital. Thus, questionnaire responses were relatively close to May's evaluation results, with the therapists polled considering the most effective treatment methods to be a Day Hospital socialization program combined with anti-psychotic drug therapy. Thus, these results do approximate May's effectiveness studies advocating a combination of drugs and psychosocial therapies.

ASSESSMENT OF TREATMENT FACILITIES VISITED

To determine whether a treatment program such as I am to develop is necessary and would be utilized, I visited with the Directors of four local Day Treatment facilities which treat schizophrenic patients. I will assess their programs in terms of clinical emphasis and program set-ups on the basis of May's evaluation studies, as well as summarize and analyze the services offered.

Saint John's Hospital Adult Day Treatment Center

At Saint John's Hospital Adult Day Treatment Center, I spoke with Terry Larson, the Assistant Director of this program. This facility offers a combination of services including Day Treatment, a comprehensive Inpatient Milieu program and Outpatient group and individual therapies. Day Treatment is focused on group activity socialization, problem solving and discharge planning, which May advocated as effective treatment for schizophrenics. Group therapies are stressed in all three forms of intervention and are oriented toward support and rehabilitation. Medication management is also an integral part of all treatment programs. In short, this facility meets all of May's requirements for effective treatment with schizophrenics.

Saint John's Adult Day Treatment program is geared to be short-term, is county funded and limits visits to approximately

five-week durations. Treatment modalities offered in this program include: Occupation Therapy (with both clinical and functional emphasis); Recreational and Socialization activities; extensive group therapy aimed toward the rebuilding of defense mechanisms; daily patient and staff meetings; individual or family therapy when warranted; and medication management. Patients are referred out for vocational rehabilitation services, but occupational rehabilitation is included as part of the work program provided in occupational therapy. Home Care is not provided, nor is the use of Megavitamins or psychosurgery. Psychodrama, Dance Therapy and Electroconvulsive therapies are only conducted in the Inpatient programs.

The Day Treatment staff includes three full-time team members: the Assistant Director of Adult Day Treatment, who is a Social Worker (M.S.W.) and who does part of the clinical supervision of all staff members; a Psychiatric Nurse (R.N. with an M.A. in Psychology); and a Licensed Vocational Nurse (L.V.N.). The balance of the staff also work with Inpatients and/or Outpatients and include: a Social Group Worker (Recreational and Socialization therapist); an Occupational Therapist (O.T.R.); another Social Worker (M.S.W.); and a Psychiatrist (M.D.), who is responsible for the overall clinical supervision of the entire Day Treatment program.

The staff at this facility work as a team and attend staff meetings to share their multidisciplined patient information and to formulate patient treatment approaches. The patients

treated at this facility include approximately forty percent formally diagnosed as being schizophrenic, with the remainder being patients with depressive reactions and deaf patients with psychiatric problems.

Neuropsychiatric Institute
Adult Development Group

I visited the Neuropsychiatric Institute Adult Development Group and spoke with its Director, Jan Matsutsuyu. The emphasis of this program is on a combination of pharmacotherapy with psychosocial activity therapies. It offers Inpatient, Day Care and Outpatient intervention focusing on problem solving, occupational and socialization rehabilitation. The principle modalities offered are group therapies oriented toward discharge planning, communication and vocational skills. The Day Treatment program at this facility is geared toward the treatment of schizophrenics and does meet May's requirements for effectiveness.

The principle modalities of treatment include: community meetings; small group preweekend planning sessions; work programs; recreation groups; occupational therapy; assertion training; and video-taped sociodrama communication skills groups; as well as group and family therapies. The social skills groups stress daily living problems, and interactional and interpersonal training skills. The groups are all very process-oriented, offering the opportunity to enhance social learning and facilitating corrective learning experiences. The emphasis is on

living more productive life with the learning or relearning of socialization skills. Home visits are made at the time of intake to assess the family's situation.

This center is a training facility and has six full-time staff members, including: two first-year resident Psychiatrists (M.D.'s); a Psychiatric Nurse (R.N. with an M.A. in Psychology); a Psychiatric Technician (L.P.T.); a Recreational Therapist (R.T.); an Occupational Therapist (O.T.R.); and a Counselor (specializing in mental health and career planning, who is non-degreed). Part-time staffing consists of: a Psychiatric Social Worker (M.S.W.); a Psychologist (Ph.D.); another Occupational Therapist; and the Program Director (nondegreed). According to Ms. Matsutsuyu, the staff is on call twenty-four hours a day.

The program is relatively short-term, lasting three months, with approximately sixty maximum visits. The discharge date is set at the time of intake, and aftercare planning is done with the families of the more chronic patients. Teamwork and inter-disciplinary training are integral parts of this program.

Di Di Hirsch
Community Adult Day Center

I visited this facility and spoke with the Assistant Director of Day Treatment, Terry McBride. Clinical Orientation is on Crisis Intervention, as well as socialization and rehabilitation. The program is geared to be short-term, and has county funding with a fifteen visit maximum, which could extend over an eight-week period. The focus in on restoration of coping mechanisms

and a building-up of ego strength while restoring the former interpersonal and occupational structure. There are Day Treatment and Outpatient services offered, with Inpatient Hospitalization available at Saint John's Hospital, as needed. Medication management is entirely assumed by this facility with control being returned to the primary physician only upon discharge. Socialization skills are taught via group activities and are an integral part of this program. Treatment modalities offered at this facility include: Occupational Therapy; Recreational Therapy; Crisis-oriented Multiple Family Therapy; Communication Skills groups; Termination groups; Assertion Training groups; Movement Therapy; and home visits which assess home conditions and family relationships. This facility also meets May's criteria of effective treatment for a schizophrenic patient population.

Staff members are on twenty-four hour emergency availability and operate within a teamwork approach. All staff members are part-time with the exception of the Assistant Director (who is a Social Worker), and include: two Psychiatric Technicians (L.P.T.'s); two Psychiatric Social Workers (M.S.W.'s); two Psychiatrists (M.D.'s); one Clinical Psychologist (Ph.D.); and several volunteers. Surprisingly, there is no nurse on staff here. Approximately fifty percent of the patients treated at this facility are formally diagnosed as schizophrenic, the remainder being borderline depressive, hysterical and severely neurotic with adult situational reactions.

David Brotman
Memorial Hospital Psychiatric Unit

Here I visited with Ann Kennedy, the Charge Nurse at the Psychiatric Unit of this hospital. This facility offers a very small Day Treatment program, which is combined with an Inpatient Milieu treatment. There are no Outpatient services provided. The setting adheres to the medical model with patient approaches planned by physicians and nursing staff alone. The program is geared to be of a short term of fifteen visits of two to three-week duration, and the focus is on crisis intervention and discharge planning. Severely disorganized patients are screened out at the time of intake. Only a very small proportion of the patients are diagnosed as schizophrenic. The majority of intakes are diagnosed as psychotic, depressive and manic-depressive.

Group activity oriented therapies are conducted with an emphasis on socialization and supportiveness. Medication management is stressed, as are diversional and social skills. Individual, Group and Family therapies are provided; one group being supportive and the other insight-oriented. Occupational therapy, vocational rehabilitation, recreational therapy, leisure skills groups, music groups, Dance Therapy and sociodrama are the modalities offered. This program does not meet the criteria specified by May for being maximally effective in the treatment of schizophrenics in its lack of Outpatient services and very small Day Treatment programs which operate in conjunc-

tion with the Inpatient program. However, the requirement of a focus on group therapy concentrating on social and occupational rehabilitation is met, as is the provision of medication management. I speculate that many of the same treatment methods and modalities may also be effective with psychotically depressive and manic-depressive patients in view of the similar approach in treatment modalities offered.

The staffing is composed of nurses (R.N.'s and L.V.N.'s), Psychiatric Technicians (L.P.T.'s), Recreational Therapists (R.T.'s), Occupational Therapists (O.T.R.'s), a Social Service Worker (M.S.W.), a Vocational Rehabilitation specialist (who incidentally is a graduate student at Lindenwood 4), a Consulting Psychologist (Ph.D.), and a Consulting Dance Therapist. There is a teamwork approach with staff meetings focusing on patient treatment plans, and interdisciplinary meetings in which the staff share their specialized knowledge of patients' behavior. There is an in-service training program for the staff as well as an outside continuing education budget available. Additionally, the staff has an insurance plan which included Outpatient therapy allotments.

Thus, three of the four facilities did approximate effective treatment programs for schizophrenics, in accordance with May's criteria. At all facilities the deficiency of good aftercare facilities for discharge referrals was mentioned. Although there appears to be a need for adequate aftercare referrals, it is not within the scope of this paper to design such a facility.

My original concentration remains that of developing an effective treatment program for schizophrenics.

In sum, there do appear to be effective treatment programs available for schizophrenics. All of those facilities visited were geared primarily for short-term stays, but did also offer programs for chronic schizophrenics. Notwithstanding the availability of such programs, I deemed it worthwhile to continue in my own effort to develop a more comprehensive, holistic program of combined elements from the various treatment approaches.

II. PROGRAM COMPONENTS AND DEVELOPMENT

INTRODUCTION

I propose to develop an integrated approach for effective psychotherapeutic treatment of schizophrenics. I shall discuss first the various therapies I wish to incorporate into this program. These therapies may well serve a number of psychological disorders. However, for purposes of this paper, the focus will be on the applicability to the schizophrenic disorder in particular. These therapies will include aspects of somatic therapy, behavioral therapy, the humanistic therapies covering client-centered, gestalt, and reality therapies as well as existential therapy. I shall also discuss the interpersonal intervention represented by family therapy and transactional analysis. Finally, I shall discuss the sociocultural approach, including the utility of the mental hospital as a therapeutic community. Additionally, in connection with this type of intervention, I shall discuss Day Hospital milieu therapy with programs focusing on recreation and socialization, occupational therapy, Dance Therapy and vocational rehabilitation counseling. Also to be covered are Outpatient and Aftercare programs.

I postulate that there is no clear delineation between treatment modalities, and that schizophrenics can be effectively treated with a combination of therapeutic techniques. As stated by Freedman and Kaplan in *Treating Mental Illness:*

Aspects of Modern Therapy:

> "The well-trained psychiatrist (or therapist) understands the indications for a wide range of treatment methods, is flexible in his approach, and is skilled in the use of these methods." (Freedman, 1971)

My emphasis shall entail a combination of modalities and methods in order to treat the multisymptomatic disorder of schizophrenia. Finally, to summarize and integrate these approaches, I shall incorporate the various therapies discussed and suggest a program which would effectively treat this disorder.

SOMATIC THERAPIES

The somatic therapies, also referred to as organic and biological therapies, present an attempt to modify or correct pathological behavior by physical or chemical means. Somatic treatment is premised on the fact that parameters of normal and deviant behavior, such as perception, consciousness, affect and the cognitive functions, can be influenced by certain physical changes in the central nervous system (Freedman, 1971). The somatic therapies which have been used in the treatment of schizophrenics include psychopharmacotherapy, Insulin Coma therapy, Nicotinic Acid, Megavitamin therapy, Electroconvulsive therapy, and Psychosurgery (May, 1976). Since organic treatment today is almost exclusively of a psychopharmacological nature, and drug therapy is the most intensively and scientifically studied method of treatment at the present time (May, 1975-a), I shall not consider Insulin Coma, Nicotinic Acid or Psychosurgery. These therapies have been largely replaced by psychopharmacology and were additionally not shown as being effective in treating schizophrenia, according to May.

Psychopharmacotherapy

Extensive research indicates that modern drugs are of great benefit in the treatment of schizophrenic patients. The most commonly used drugs are the major tranquilizers, such as chlorpromazine and haldol, which are thought to control agitation, excitement and thought disorders; antidepressants, which are

used to increase interest and alertness, and to elevate mood; and the minor tranquilizers or antianxiety drugs, which are used to decrease tension and apprehension and to promote sleep (Coleman, 1976). These drugs frequently are used in combination, and the major tranquilizers may even be used for periods of years. Coleman, in *Abnormal Psychology and Modern Life*, states that acute schizophrenic patients, as part of treatment programs, usually respond readily to drug treatment, showing a rapid alleviation of symptoms, but that the more severe and chronic patients respond more slowly, with their delusions and hallucinations being gradually eliminated (Coleman, 1976).

May's study, "Schizophrenia: Evaluation of Treatment Methods," determined that psychosis recurs in a significant number of patients when phenothiazines (the major tranquilizers) are withdrawn; often not until three to six months after discontinuance (May, 1975-a). Therefore, it appears necessary to continue drug maintenance therapy as an integral part of the treatment program for schizophrenics, for supervision purposes. Drug dosage must also be monitored with extreme care, trying to reduce the dosage to the minimum level that will alleviate the psychotic lack of ego controls and faulty perception with the least interference with positive ego functions and learning (May, 1975-a). However, drugs do not help everyone, and especially in large doses, can produce troublesome side effects that work against psychological and social therapy. May, in

his article, "Rational Treatment for an Irrational Disorder: What Does the Schizophrenic Patient Need?" expresses this point:

> "The skill in drug therapy is to avoid large doses except in the early stages of treatment or in unusual situations and to monitor the treatment process closely so that dosage can be adjusted to a trade-off point that is optimal for the current goals of treatment. In general, the closer the patient becomes to 'normal' the more we should be careful to reduce drug dosage to the minimum required for maintenance of perceptual control." (May, 1976)

As stated earlier, May's study had conclusively shown that drug therapy is advantageous in any hospital setting and the results with drug therapy are likely to be better, at least in terms of employment and release rate, in a more intense treatment milieu, and worse when the level of milieu is grossly deficient (May, 1975-a). This points again to the need for combining psychopharmacotherapy with other effective psychosocial and sociocultural approaches to therapy with schizophrenics.

I believe that it is of utmost importance for patients to be apprised of what to expect while on drug therapy, including the areas in which they can expect relief and in what amount of time, as well as the common possible side effects such as drowsiness and dry mouth, which can be alleviated by an additional drug. Patients should also assume as much responsibility as deemed possible for taking their medications on time, as self-medication after discharge is also an important part of the total treatment plan.

Many articles have been published about controversial drug treatment issues. Otto Will, in "Schizophrenia: Psychological Treatment," states that oftentimes drugs may be used more for the sake of the therapist and other staff members than for the needs of the patient (Will, 1975). I infer that he is referring to the many staff members who become anxious and fearful when schizophrenics exhibit peculiar and inappropriate behavior, or hallucinate, and advocate drug therapy to reduce their own anxiety by controlling such behavior.

Thus, the physician prescribing the medication should take this into account, but should also seek feedback from the treating therapists regarding their observations. In my experience, many patients often forget to tell their physician about overmedication side effects. Clearly, the therapist is in an excellent position to observe the daily behavior of patients and therefore to report any unusual effects to the prescribing physician.

Electroconvulsive Therapy

Theories of exactly how Electroconvulsive shock operates to alter human cognition, perception, emotion and behavior are many, contradictory and confusing. Philosophical, psychological and physiological explanations of all sorts have been tendered, but it is still unclear why it works. Even so, the fact that it does work has been accepted by many psychiatrists (McNeil, 1970). I have personally observed patients helped on a short-term basis with Electroconvulsive therapy.

As with all other forms of treatment with schizophrenics, Electroconvulsive therapy is most likely to have a favorable outcome if the disorder had an acute onset and has existed for only a brief period before the commencement of treatment. It is not likely to be effective in long-term, chronic hospital cases or in those patients with repeated readmissions (May, 1975-a).

The procedure for the artificial production of convulsive seizures in patients involves, first, the injection of a curare-like muscle relaxant to soften the severity of the seizure and to prevent fractures during the convulsion. This is followed by the application, via electrodes placed at both temples, of from 70 to 130 volts for a period of about 0.5 seconds to induce a seizure lasting slightly less than one minute. The seizure resembles the grand mal attack experienced by epileptics. Treatments are administered two or three times a week and may range from five to thirty or more in number. After shock, there is an impairment of memory and learning ability, but these and confusional states clear up shortly (McNeil, 1970).

I have varying thoughts about the usage of Electroconvulsive therapy. I have seen it work well on a short-term basis, with agitated depressive and manic patients. However, improvement is not cure and it does not guarantee a complete remission of symptoms. Psychoactive drugs would be the preferred mode of organic treatment since there is no evidence that Electro-

convulsive therapy is more beneficial to drugs (Lauler, 1970). Additionally, in May's evaluation study, one group of patients received Electroconvulsive therapy alone, with the outcome intermediate between that for milieu therapy alone and that for drug therapy alone (May, 1975-a). I do, however, see the advantage of Electroconvulsive therapy as an occasionally helpful treatment modality in drug-resistant patients. Therefore, I see Electroconvulsive therapy as an adjunct of the treatment program, to be utilized only in drug-resistant Inpatients, whose schizophrenic symptomology is complicated by assaultive and violent behavior or severe depression which is not controllable by drug therapy. Electroconvulsive therapy, then, would be available for treatment of Inpatients on a very infrequent basis or not used at all, as the case may warrant.

To conclude, I wish to include drug therapy as an integral part of my treatment program and have Electroconvulsive therapy available on the rare occasion when drug resistance is evidenced. I propose that pharmacotherapy should be combined with elements of psychosocial, interpersonal and sociocultural therapies, which I shall proceed to discuss.

PSYCHOSOCIAL THERAPIES

In this section I will be covering various forms of psychotherapy including the following: Behavioral, Humanistic and Existential, and Interpersonal therapies. Also included will be the two basic methods of psychotherapy: individual and group. All of these therapies have common ground in their attempt to help schizophrenic patients reestablish bonds of human relatedness, eliminating specific psychotic symptoms, correcting distorted attitudes, and developing needed interpersonal and other competencies for coping in a more adequate way (Coleman, 1976).

All of the aforementioned psychosocial therapies also attempt to modify the personal makeup or characteristics of the patient and their interpersonal interactions and relationships which influence the individual's development and/or behavior (Coleman, 1976).

Since individual therapies aimed at psychological insight and understanding (i.e., classical psychoanalytic and rational emotive therapies) were not shown by May's studies as being effective in the treatment of schizophrenia, I shall not include them as a part of my program. I will next cover group therapy in general, as well as those specific approaches, which were proven effective. Finally, I shall delve into the specific types of psychosocial therapies, as I believe a combination of these are necessary for a comprehensive and effective treatment program for schizophrenics.

Individual Therapy

There are many types of individual (or one-to-one) therapy which are amenable for use with schizophrenics. I will cover each applicable one separately, and point out the relative value of each. Most of these types of therapy, including client-centered, existential, transactional analysis, reality therapy and gestalt therapy, can also be done on a group basis. In this section, I intend to summarize some of the problem areas on which schizophrenics in particular need to work, as well as a few of the ways a therapist might deal with them.

The ego strengths of schizophrenics are usually quite low, often overshadowed by their defenses. I believe that the therapist must support, encourage and develop these ego strengths, and let the patient know that the therapist has faith in the patient's potential, regardless of how bizarre or hostile the behavior may be at any given moment.

The schizophrenic patient is often withdrawn and afraid to make any demands of life that might lead to pleasure and satisfaction. The therapist must begin by attempting to form a relationships, which may initially involve a scrupulous observation of distance until the patient is able to develop trust. This type of patient avoids defining the relationship with another person. Such patients can also be exasperatingly skillful at preventing another person (therapist) from defining the relationship (Haley, 1963). Haley, in *Strategies of Psychotherapy*, advocates that the therapist gain control of the relationship, stating:

> "The psychotherapy of schizophrenics requires unique techniques because of the peculiar unwillingness of the patient to indicate that what he does in response to another person. To persuade the patient to indicate a type of relationship, it would seem obvious that the therapist must gain control, or direction, of the patient's responsive behavior." (Haley, pg.112, 1963)

Basically, Haley holds that one way to gain control of a schizophrenic's behavior is to initiate a situation in which the patient cannot avoid responding to the therapist. He says that the patient must be trapped so that directions are followed regardless of responses and in so doing, the patient is participating in a relationship (Haley, 1963).

I conceive of the psychotherapeutic process as one of learning. In my opinion, the schizophrenic patient needs to relearn many aspects of social and cognitive development. Socialization may have to be retaught in terms of alleviating fear of others, avoidance of relationships and isolation. A therapist must employ a variety of techniques to deal with the symptoms of cognitive and social dysfunctions. Specific techniques of the major schools of therapy will be discussed as I cover each approach separately. However, I believe that no matter which approach is utilized, it is important to review the patient's development and behavioral patterns to illuminate his current ways of living, as well as to convey the idea that the therapist really does want to understand the patient. I do not advocate any pretense on the part of the therapist, which would likely be defeated by the astutely perceptive schizophrenic.

The main goals in working with schizophrenic patients, as I see them, are to improve communication, enhance coping abilities, develop effective social skills and increase self-reliance and responsibility. Although much the same goals are striven for with neurotic clients, these goals are absolutely imperative for the very functioning of the schizophrenic. As previously stated, the treatment methods to be discussed may be applicable to various psychological disorders. Therefore, discussion will be limited to their relation to schizophrenia for purposes of this thesis.

Group Therapy

Group therapy is psychiatric treatment involving two or more patients participating together in the presence of one or more psychotherapists. The latter facilitates both emotional and rational cognitive interactions to effect changes in the maladaptive behavior of the members (*Comprehensive Textbook of Psychiatry* - 1975). Group therapy can provide the schizophrenic patient with a therapeutic atmosphere that supports reality orientation and encourages relating to others to combat feelings of fear and distrust (Sadock, 1975).

The socially supportive orientation of the group setting is particularly helpful in treating schizophrenics who quite often are socially isolated and withdrawn. In group treatment with schizophrenics, I have observed very positive results when outside contact among the group members is encouraged,

since the group often provides their only socialization experience in their otherwise often bleak existence. Unlike individual psychotherapy, group therapy allows the therapist to observe interpersonal behavior directly, without reliance solely on the patient's reports of experiences. Additionally, the patient is able to receive feedback from other members in a safe environmental setting.

Clinical experience has shown that the behavior patterns manifested by each group member initially are similar to those shown outside the group. These patterns are scrutinized as they unfold, just as are the inner processes of thinking and feeling (Sadock, 1975). Also, some patients feel more open, secure and trusting in the group setting, which they perceive less threatening than the close one-to-one relationship in individual therapy (May, 1975-b). Group therapy offers the opportunity for peer confrontation, testing consensual validation and decreasing the patient's own sense of isolation. However, other patients in the group may interact and interpret in ways that threaten a particular patient's defense system. Overcoming this difficulty requires skillful handling by the therapist (Sadock, 1975).

In conducting group therapy with schizophrenics, it is helpful to know what particular type of group therapy is most suitable, since some are more adaptable for neurotics. Patients are usually treated in groups homogeneous for psychotic states and the leader is usually active and directive (Sadock, 1975).

A typical group therapy composed of mainly psychotic patients is described by Kaplan, as follows: Potential and actual hostility toward the leader may be intensified because of schizophrenic ambivalence. The members often additionally show great dependence on the leader. Peer transactions need encouragement and autonomous functioning by the group as a whole is difficult to achieve. Members may resent participation and devalue the group, and they are more susceptible to therapist approval than to group pressure. Group standards require repeated confirmation by the leader since they are not adhered to consistently. Communication is inhibited, with little sharing of experiences; mutual identifications are not prevalent and patients tend to feel alone. Associations of members may have autistic qualities influenced by a group event or possessing a common theme. The schizophrenic group is more prone to aggressive acting out rather than to sexual acting out, and the expression of affect may have to be curbed. Accurate interpretations of unconscious conflicts may be suppressed by the leader and usually dream interpretation receives little emphasis. Patients typically tend to project intrapsychic conflict and do not accept group behavior as related. They deny that behavior is a manifestation of original family group experiences. As far as problem patients, the monopolist is most common and is poorly managed by members; suicidal ideation is common and members utually withdraw in crisis, and the leader must

exert control. The goals of this type of group therapy are to relieve specific psychiatric symptoms and to improve functioning in one or more areas for the majority of patients (Kaplan, 1971).

Reality testing by the group as a whole may be poor, and delusions and hallucinations not subject to reality testing may appear. The therapist must encourage honest and open communication within the group so that a constant assessment of reality can take place. In successful reality testing (the objective evaluation of the world and realistic awareness of oneself and others), the patient is able to separate reactions appropriate to current stimuli from those that are carry-overs from past conflicts (Sadock, 1975). The therapist can attempt to elicit conscious recollections from the patient subject to this type of distortion, concerning the various ways a particular member, might for instance, resemble a family figure of one of the patients. Or one might make the interpretation directly in an effort to bring such associations to consciousness.

MacNab, in his book, *Estrangement and Relationship: Experience with Schizophrenics*, stressed that the group often becomes an end in itself as far as the formation of relationships:

> "...not only a means for therapy; it can become an end in itself. In the group, the patient is directed beyond preliminary issues of cure, to the ultimate issue of the relationship between himself and the other. In the group situation, an attempt has been made to bring to the patient an awareness of the primacy of the self-world relation..." (MacNab, 1965).

I accept the validity of MacNab's opinion in view of my own experiences. Often these types of patients are forming relationships for the first time. Such an experience can have a very valuable meaning.

Another issue which warrants consideration pertains to the phenomenon that psychiatric patients when beginning therapy are often demoralized and possess a deep sense of having nothing of value to offer to other group members. In a group therapy setting, they have an opportunity to receive through giving (of support, reassurance, suggestions, insights, sharing similar problems) to the other members, which consequently can help to raise their self-esteem levels.

Yalom, in his book, *The Theory and Practice of Group Psychotherapy*, points out that oftentimes other group members are keenly aware of discrepancies between the schizoid patient's words, experiences and emotional responses, and their response then proceeds from curiosity and puzzlement into disbelief, solicitude, irritation and frustration as they try to force an affective response. It is Yalom's opinion that the therapist must avoid joining in this quest for a breakthrough, since, as a result of excessive one-to-one directive work, the group may become less potent, less autonomous, more dependent and more leader-centered. For these reasons, he advocates screening out "marked deviants" (psychotics) and forming homogeneous groups (Yalom, 1967). I agree with this theory and accept the concept of only considering patients whose needs will be relative to the goals of each particular group.

In summary, I believe that group therapy is the best modality for use with schizophrenics as it provides the socialization they need; in a nonthreatening atmosphere it can be a safe place for them to receive feedback on their behavior as well as to test their own reality. The role that I see a group therapist taking with a psychotic population would be one of strengthening the existing defenses of the members, encouraging intragroup dependency, and taking a generally active part. Group therapy with schizophrenics should focus on learning from the experiences of others, testing one person's perceptions against those of others, and correcting distortions and maladaptive interpersonal behavior by means of the feedback from other group members, as well as the therapist. I conceive of these concepts working on both long- and short-term group therapies.

Behavior Therapy

Behavior therapy, also known as behavior modification, is based mainly on the method of operant conditioning first described by Skinner, in which actions either lead to reward or produce painful stimulus, thereby changing behavior by reinforcement or extinction (May, 1975-b). This therapeutic approach utilizes the systematic application of learning principles to the modification of maladaptive behavior either on a group or individual level. As previously stated, the behavioristic model views the maladjusted person has having learned faulty coping patterns or having failed to acquire needed competencies for coping with the problems of living (Coleman, 1976).

This theory can be applied to many of the schizophrenic symptoms. For example, delusional statements can be extinguished by ignoring them and by responding only to the wanted responses. And so-called "normal" behavior can be rewarded by positive reinforcement by either approval giving (social reinforcement) or by a privilege token-type system (secondary reinforcement). I conceive of this approach as very effective in the treatment of schizophrenics since they exhibit many behavior problems. At the time of May's evaluation study, behavioral conditioning was virtually untested by controlled studies (May, 1976).

The immediate and foremost concern of the behavioral therapist is to establish objective goals, detailing specific and troublesome behavior, selecting priorities, and concretizing a list of social skills (Loew, et al, 1975). The approach is cognitive and task-oriented. The behavioral therapist looks at patients in terms of the skills they possess or lack to bring about positive reinforcement (Loew, 1975). This is a highly structured form of treatment and motivation is maintained at high levels. The therapist is seen initially as the "teacher" or "model," and the patient as the respected "student." In this approach, the therapist actually educates the patient about human behavior)Loew, 1975). According to Loew, et al, in *Three Psychotherapies: A Clinical Comparison*, more so than psychoanalysis and gestalt therapy, behavior therapy continually focuses on developing and maintaining motivation for treatment (Loew, 1975).

As mentioned earlier, I do advocate parts of this approach in the treatment of schizophrenia. However, this type of approach could conceivably be carried too far. For example, I do not recommend the use of token economy systems on hospital wards to gain privileges. I believe psychological growth as well as behavioral changes merit approval. Behavior therapy would work best, I believe, when adhered to as specified in individual treatment plans. In this way, the particular behavioral deficits could be clearly delineated and the goals explicitly defined.

Assertion training may also be utilized in this type of approach as a method of desensitization as well as a means of developing more effective coping techniques (Coleman, 1976). Assertion training aims to teach individuals ways of increasing personal power to interpersonal situations without endangering relationships. From personal as well as professional experience, I have found that the use of assertive communication techniques usually results in increased self-respect combined with increased positive impact on others. Thus, I advocate assertion training for inclusion in an effective program for schizophrenics as it can enable patients to work through the anxiety normally experienced at the thought of expressing wants and feelings directly, as well as to learn the corollary skills to enable them to speak out effectively.

According to Carkhuff and Berenson, in *Beyond Counseling and Therapy*, there is extensive evidence that behavior modification techniques are effective with patients functioning on a level similar to schizophrenics. They describe such patients as the severely disabled person who is out of contact with his world, unable to engage in constructive human encounters, and experiencing a breakdown of the communication process (Carkhuff, 1967). Carkhuff and Berenson reiterate the point that the behavior modification approach is geared to minimal coping with the world and is not geared to go beyond the fundamental relief of symptomatology (Carkhuff, 1967). Thus, although it does bring the patient to a point where basic symptomatic behavior can be altered, it does not provide the patient with experiences and conditions for self-fulfillment or self-actualization (Carkhuff, 1967). For these reasons, I believe that employing parts of the humanistic and existential approaches would be more suitable at the time that individual patients are amenable with specific symptoms alleviated.

Thus, I do advocate the behavioral approach for use in conjunction with psychopharmacotherapy to obtain fundamental relief of symptomatology. At this time, I believe the patient would perhaps be more ready to utilize aspects of the humanistic and existential therapies in order to meet the demands of living more creatively.

Humanistic-Existential Therapies

Proponents of humanistic and existential therapies view psychopathology as stemming from problems of alienation, depersonalization, loneliness and the lack of meaningful and fulfilling existence (Coleman, 1976). Their viewpoint is based on the assumption that we have the freedom to control our own behavior, reflect upon our problems, make choices and take positive action (Coleman, 1976). Therefore, humanistic and existential therapists feel that the client (or patient) must take most of the responsibility for the success of therapy. Such a therapist serves as a counselor, guide and facilitator, as well as provider of basic support to the patient when needed. My own personal viewpoint of therapy follows these lines. However, in dealing with schizophrenics who are often not able to take most of the therapeutic responsibility, or able at times to make rational choices, it is also of great help to have other methods at your disposal. For example, although most of therapy justifiably requires the patient's cooperation to be effective, many behavioral problems are best dealt with by beginning with the behavioralistic model. Again, I am proposing an integrated treatment approach which best suits the individual schizophrenic patient's immediate needs.

Client-Centered Therapy

Client-centered therapy is a form of psychotherapy formulated by Carl Rogers, in which the patient is believed to pos-

sess the ability to improve. The therapist merely helps clarify the patient's own thinking processes and expression of feelings. The client-centered approach in both group and individual therapy is democratic, unlike the therapist-centered treatment methods (*Comprehensive Textbook of Psychiatry*, 1975). The central hypothesis is that the growth potential of any individual will tend to be released in a relationship in which one person (the therapist) is experiencing and communicating realness, caring and a deeply sensitive nonjudgmental understanding (Rogers, 1975). Thus, the patient reciprocates the therapists' attitude, is able to listen to communication from within, and is more able to move toward congruence in total expression more openly (Rogers, 1975).

I find many of the inherent principles in this approach valuable therapeutically; particularly its orientation to the process of relationship, rather than to symptoms or cure as in behavioral therapy. Many schizophrenics have never participated in a healthy relationship and would benefit from this experience in the building of trust and confidence in another. The client-centered therapist does not offer advice or suggest "right" ways of behaving, but instead restricts interaction to reflecting and clarifying the patient's feelings and attitudes (Coleman, 1976). This would assist the patient in feeling unconditionally accepted, understood and valued as a person, consistently with the attitudes identified by Carkhuff and Berenson as being effective therapist qualities. This approach will be

integrated as part of my proposed treatment program, as it complies with the effective therapeutic qualities and facilitates growth in a warm psychological climate.

Existential Therapy

Existential therapy places emphasis on confrontation, primarily in the here-and-now interaction, and on feeling experiences rather than on rational thinking (*Comprehensive Textbook of Psychiatry*, 1975). It is based on existential philosophy which holds that humans have the responsibility for their own existence, and emphasizes the uniqueness of the individual and a "way-of-being-in-the-world" (Coleman, 1975). Thus, existential therapists focus on a broad understanding of the subjective schizophrenic experience and their own ways of relating (May, 1975-b).

R.D. Laing contends that schizophrenia is a label pinned by a troubled society on some of its more difficult, different members. He also suggests that madness is an understandable, possibly even creative, response to the evils of contemporary life (Gordon, 1971). Laing conceives of the isolation and submergence of the personal identity as the schizophrenic's defenses against feelings of being swallowed up, crushed or being treated as a thing rather than a person. Laing's approach to treatment consists of,

> "guiding the patient through his psychosis on an inner voyage of exploration into inner time and space so he may emerge as a better and more enlightened person than before." (May, 1975-b)

Laing has created new places for schizophrenics to work things out and to discover the wholeness of being human between them, such as Kingsley Hall, where they are encouraged to regress and be what they feel (Gordon, 1971).

Proponents of the existential approach express much criticism of the medical model and are often referred to as Anti-psychiatrists in the literature. They critically examine the question of whether medicine should be responsible for the treatment of the mentally ill, conceived of as one type of society's deviants - the old and irrational (Mosher, 1975). Laing, Swasz, Cooper, Scheff and Goffman comprise parts of this sociopolitical movement. I agree with a part of their philosophy, namely the desire for redefinition of psychosis as a social-interpersonal situation rather than a disease. The stigma attached to schizophrenia is an unnecessary additional burden on an already troubled patient. Thomas Szasz concludes his book, *Schizophrenia*, by stating that schizophrenia will remain the central "problem" of psychiatry so long as society supports the personnel and the practices now defined as therapeutic; it will cease to be a problem only when society withdraws its support from these interventions and from the individuals and the institutions that now promote and profit from them (Szasz, 1976).

I wish to incorporate a part of the existential philosophy into my treatment program; specifically, that pertaining to the theories of isolation and alienation central to many of the

schizophrenics' problems and the removal of labels. This standpoint, I believe, may create a more positive context in which to view treatment. Clancy Sigal examplifies the existential viewpoint in his article, "Shellshock Schizophrenia," as he described his views on relating with schizophrenics:

> "I learned to have the utmost respect for the spectacle and insights of their condition. Their mental quickness, poetic and lightninglike connections, the sheer marvelousness of so much schizophrenic language constantly amazed me. Being with schizophrenics is the most exhilarating roller-coaster ride in (or out of) the world. It is a state devoutly to be desired - within limits." (Sigal, 1977)

I, too, advocate entry into the patient's inner world. However, I envision distinct limits imposed upon the therapist's own involvement. I do not find it effective therapy when therapists become so personally involved as to lose sight of their own egoistic selves. Sigal profoundly states how to handle this situation:

> "One way, perhaps, is to try to slightly close the gap between reality and fantasy in all our lives so that the burden of the schizophrenic dream does not always fall so heavily on those least able to carry it." (Sigal, 1977)

He suggests acknowledging our own madness to lighten the load on those whom we, in our fear of madness, label as mad. Yes, I have found madness of some form in all humans - perhaps it is what imbues each of us with uniqueness.

Gestalt Therapy

Gestalt therapy emphasizes the treatment of a person as a whole and focuses on sensory awareness of the person's here-and-now experiences, rather than on past recollections or future expectations (*Comprehensive Textbook of Psychiatry*, 1975). There is a focus on action rather than understanding, and the therapist uses specific techniques to evoke feelings (Loew, 1975). Concerning schizophrenia, a gestalt therapist conceivably could use the concept of confluence to understand the schizophrenics' attempt to avoid contact with themselves and their world through the feeling of no change or excitement (Loew, 1975). Gestalt therapy emphasizes the unity of mind and body, placing strong emphasis on the integration of thought, feeling and action (Coleman, 1976).

According to Perls, the developer of gestalt therapy, we all go through life with unfinished or unresolved traumas and conflicts which we then carry into new relationships. Therefore, we act out our tensions in our relations with other people. Thus, Perls advocates the completion of past, unfinished business in order to reduce psychological tension and promote a more realistic awareness of self and world (Coleman, 1976). Many of the techniques of this approach can be applied in the treatment of schizophrenia. For instance, to increase awareness of self and of areas of avoidance, a patient could be asked to act out fantasies concerning feelings and conflicts to help perceive those aspects of self and of the perceived world which are "blocked out" (Coleman, 1976).

A gestalt therapist wants to increase the awareness of body sensations and feelings to give the patient practice in becoming comfortable with them (Loew, 1975). I led sensory awareness groups with schizophrenic patients and found the technique helpful to direct a focus on the body and promote trust among the group members. Additionally, the gestalt therapist's focus on the "here-and-now" is useful in treating schizophrenics who often appear to be in their own world.

In group work, a gestalt therapist takes an active role and insists that exchanges among group members faithfully reflect their true feelings about each other (Strupp, 1975). Such an approach could help make schizophrenics aware of others' perceptions of them, and perhaps lessen feelings of social withdrawal and isolation.

Schizophrenics especially need help to enhance their awareness of their physical state, as they are often totally out of touch with these feelings. I recommend that aspects of gestalt therapy, such as sensory awareness techniques, role playing and the focus on the person as a whole be included in the treatment approach to schizophrenia. However, since many of these techniques could be very threatening to many patients, I think that they need to be utilized with caution, so as to leave ego functions and some defenses intact. For example, gestalt therapy concentrates heavily on dealing with resistances instead of offering affirmation. For this reason, I do not consider it as a supportive therapy unless used with careful evaluation with schizophrenics.

Reality Therapy

Reality therapy is associated with the work of William Glasser. His basic premise is that all persons in need of psychotherapeutic help deny reality and are unable to fulfill their essential needs (Strupp, 1975). Basic needs relevant to psychiatry are the need to love and be loved and the need to be worthwhile to others and to ourselves. Responsibility, which is another key concept of reality therapy, is defined as the ability to fulfill one's needs and to do so in a way that does not deprive others of the ability to fulfill their needs (Strupp, 1975).

This approach views mental patients as not having learned, or having lost the ability to lead responsible lives (Strupp, 1975). Thus, "responsible" stands for "mental health," and "irresponsible" for "mental illness." Glasser describes therapy as,

> "...a special kind of teaching or training which attempts to accomplish in a relatively short, intense period what should have been accomplished during normal growing up." (Glasser, 1965)

Thus, therapists are seen as parents or teachers who are responsible, tough and sensitive, and who set examples, demonstrate and instruct (Glasser, 1965).

Reality therapy, in my opinion, can be very effectively applied in the treatment of schizophrenics. Due to the nature of their basic problem areas, these patients in particular need to be retaught to take responsibility for themselves. Therefore, I see those therapies dealing with reteaching well-suited for treatment of schizophrenia. I postulate that a growing sense of self-

worth is concommitant with patients' efforts to become responsible and that guilt feelings will also diminish as a result. I believe this approach has a place in the treatment of schizophrenics, and should therefore be part of the overall integrated treatment program.

Interpersonal Therapies

The Interpersonal therapies focus on relationships rather than individuals. The focus is on the role of faulty communications and interactions. I shall cover family therapy and the Interpersonal technique of transactional analysis in this section.

Family Therapy

Family therapy is a therapeutic intervention centered on the family system, rather than the individuals within it. This form of therapy can focus on many different dimensions of family relationships, such as defective communication techniques, diffusion of authority, blurring of roles and symbiotic fusion of identity, among others (May, 1975-b). Family therapy can especially be helpful in working toward lessening the degree of the family's participation in and production of the identified patient's psychosis. Typically, family therapy adopts the concept that the problem of the identified patient (i.e., the schizophrenic) is often only a symptom of a larger family problem (Coleman, Foley, etc., 1976).

Perhaps paradoxically, the study of family dynamics started with the study of the most pathological of families, those of schizophrenics. Lidz, Jackson, Bateson, Bowen, Wynne and Ackerman were among the first to study the family dynamics of schizophrenic patients. Their conclusions were that a dynamic equilibrium functioned in some families to maintain the labeled patient in the sick role and further that some families needed to scapegoat and exclude the sick member (Harz, 1975). Thus, the identified patient (or the schizophrenic) is blamed first for being sick and then for being the cause of all the family's problems.

There are numerous methods of family therapy, including variations on the structural, systems and developmental theoretical models. An attempt to discuss them comprehensively at this point would be inconsistent with the purposes and limits herein. Instead, I shall briefly discuss family crisis therapy, as I believe it is helpful in the treatment of schizophrenics.

Ackerman, in *Treating the Troubled Family*, describes the goals of family crisis therapy as achieving a clear definition of the real conflict, relieving distressed and disabled functioning and strengthening shared resources for problem solving. Also included are reducing conflict and improving the level of coping, encouraging the substitution of appropriate controls and defenses for inappropriate ones, and bolstering immunity against disintegrative effects of emotional upset (Ackerman, 1966).

Family therapy should be an integral part of the treatment program for schizophrenics since the family is usually involved at the beginning of the patient's problems and vice versa. The improvement of the schizophrenic is contingent upon changes in the family constellation and interactional patterns, as the patient most often rejoins the family, if possible, at discharge (Harz, 1975). Family therapy, as I conceive it, could be done with multiple family groups as well as individual family groups to deal with family pathology.

Transactional Analysis

This approach, derived from the work of Eric Berne, postulates that the human personality is composed of three "ego" states: parent, adult, child. Strupp, in "Recent Methods of Psychotherapy," refers to them as coherent organizations of intellect and emotion (Strupp, 1975), corresponding very roughly to Freud's id, ego and superego (Coleman, 1976). According to Berne's theory, the parent ego state consists of introjected parental values and admonitions, with associated criticism and orthodoxy. The adult ego state is that aspect of the personality which evaluates the demands of the environment objectively, with unemotional calculation of the reward potentials of possible behavior being associated with it. And last, the child ego state is the spontaneous, childlike component of the personality with irrational fear, inferiority and joy being associated with this child state (Strupp, 1975). Within the

framework of this theory, I postulate that schizophrenics often operate in the child state, therefore needing to obtain more effective ego control since the adult is essentially decommissioned (Berne, 1961).

Berne characterized our social interactions as "games," because they are played according to a set of unspoken rules (Coleman, 1976). By analyzing the "games" we play, transactional analysis can make us aware of our basic coping patterns and their consequences in interpersonal relationships. I speculate that schizophrenics are probably involved in playing several games, and that transactional analysis could be beneficial in their treatment. I would therefore include it as another approach in the treatment of schizophrenics.

SOCIOCULTURAL APPROACHES TO THERAPY

In this last phase of my program development, I will discuss sociocultural approaches to therapy. These approaches typically involve the modification of the individual's life situation in order to provide a more supportive or therapeutic environment (Coleman, 1976). Thus, I will cover the therapeutic community type of hospitalization, partial hospitalization, Outpatient and aftercare, including recreational socialization and occupational therapies as part of these approaches. These approaches are most definitely the basis of the entire treatment program for schizophrenics, and require integration with the psychosocial and somatic therapies to be comprehensive and effective.

Therapeutic Community Hospitalization

Maxwell Jones introduced the term "therapeutic community" in 1953. It refers to a specific treatment modality based on the premise that a psychiatric ward or hospital is a social system influenced by its members (Daniels, 1975). Thus, the ongoing activities of the hospital are brought into the total treatment program, and the environment, or milieu, is a crucial aspect of therapy (Coleman, 1976).

The therapeutic community operates under definite principles and practices. The first is that communication must be open and direct between staff and patients. Patients are encouraged to participate actively in their own treatment (Daniels,

1975). For schizophrenics, this could give a feeling of once again assuming importance and control of some decision-making. For staff, it could be an opportunity to receive feedback in order that the program could be further adapted to the needs of all participants.

This modality reduces the emphasis on the medical model concept of physician authority. There are additional attempts made to avoid the social isolation and dehumanization as seen in large institutions. In a therapeutic milieu community, the unit and hospital remain in close contact with the outside community (Daniels, 1975). Thus, schizophrenics are discouraged from making a permanent refuge from the world and escaping into a chronic "sick" role (Coleman, 1976).

The concept of the therapeutic community is similar to the extended family concept and can be applied to many institutions. For example, at Lindenwood College, participants are encouraged to participate actively in their programs and open and direct communication is encouraged. Its governing system is open to change and is dependent on both administration and participants to make it a viable and meaningful experience. As in the psychiatric therapeutic community, Lindenwood also attempts to avoid the dehumanization of the larger counterparts by operating with the principle of interrelatedness. In this way, all participants' needs can be met, the process is perceivable and can be experientally integrated.

Therapeutic community approaches, such as I am advocating in the treatment of schizophrenics, involve a multidisciplinary teamwork approach. In this framework, there is frequent and open sharing of patient observations, and of the treatment program as a whole. Some therapeutic communities advocate a prescribed milieu attitude for homogeneity (Daniels, 1975). I do not always recommend this, as I believe it reduces the staff's naturalness and spontaneity. However, there is of course, usefulness in limiting acting out behavior, etc., so as to have a uniform approach to these problem areas.

The therapeutic community attempts to create a different type of attitude and behavior in the patients, as well as a different atmosphere in the unit (Daniels, 1975). As previously mentioned, the patients are encouraged to be active collaborators in their treatment. They therefore take increasing responsibility for their current life situations, while living in a community where their contact with others becomes therapeutic and rehabilitative (Daniels, 1975). Thus, patients can act as therapeutic agents for each other. I see this as particularly beneficial for schizophrenics, as such an atmosphere would tend to reduce regression and shorten hospital stay.

I definitely advocate this type of therapeutic milieu during required hospitalization, but I believe the hospital stay should be as short as possible to prevent the development of a dependency on the hospital. Additionally, I believe discharge planning should be done from the time of admission, so

both patients and staff are operating with the same understanding. I believe that the hospital milieu should approximate community living as closely as possible. I find the therapeutic community approach also viable for a partial hospital setting.

Partial Hospitalization

Partial hospitalization includes Day Hospitalization, Night Hospitalization and evening or weekend hospital care. Great impetus for developing this type of hospitalization was provided by the National Institute of Mental Health (Herz, 1975), which specified that Day and Night hospitalization were essential components of federally funded community mental health center assistance grants in the statute of 1963. The aim was to provide flexible, comprehensive and continuous care to patients within local communities as a preferred substitute for long-term custodial care in large State hospitals (Herz, 1975). Included in this provision were Inpatient hospitalization, Outpatient care, 24-hour emergency care, and consultative and educational services to local community groups and agencies. It is obvious that this act was initiated in the hope of developing innovative alternate approaches to the prevailing institutionalization, which had led almost all those diagnosed as being schizophrenic (among others) into being considered as chronic and hopeless.

I believe it will be helpful at this time to review some preliminary operational definitions so as to begin with a basic understanding of the different models of partial hospitalization therapies which I shall touch.

Day Hospitalization is a structured psychiatric treatment program attended by patients five days a week, excluding weekends, from 8:30 a.m. to 5:00 p.m. Ordinarily, patients eat breakfast and dinner at home and have lunch at the Day Hospital.

Night Hospitalization is set up on the premise that the patients usually work or attend school and return to the hospital for dinner. They then participate in the evening activities and sleep at the hospital. In evening and weekend hospital care, patients function in jobs or school and return to the hospital for evening or weekend treatment programs (Herz, 1975). It appears in my research that most of the psychiatric literature regarding partial hospitalization deals with Day Hospital, which is apparently considered to be the most important and most highly developed of the various forms of partial hospitalization (Herz, 1975).

Herz has evaluated studies of types of hospital programs regarding therapeutic outcome, His emphasis was shifted from a concern with how well a patient adjusted to the hospital milieu to an evaluation of the patient posthospitalization adjustment to the community, which included gaining employment (Herz, 1975). Herz cited one particular study by Anthony, et al, 1972, which showed that it does not seem to matter whether

hospitalized psychiatric patients received eclectically-oriented group therapy, psychoanalytically-oriented individual or group therapy, pharmacotherapy or somatotherapy as recidivism and employment rates were not differentially affected. Therefore, it was concluded that the most effective treatment program would be one that did not remove the patients totally from their families and community. I can well appreciate this finding in light of the fact that a program which places patients in an artificial environment (the hospital) and places total importance on how well the adjustment is, would not be of consequence in how well the patient would readjust to the everyday world.

I definitely advocate the use of a Day Hospital setting over an Inpatient setting as soon as the patient is able to tolerate it. The Day Hospital serves many functions. I see it as an alternative to Inpatient care, a transition from Inpatient care and an alterative to Outpatient care. Herz, et al, conducted a study in 1971 which showed that a shorter initial hospital stay associated with Day Hospital was followed by a lesser likelihood of readmission. Day Hospital is ideal, it seems to me, in serving the purpose of gradually reintroducing the patient into community life. There is, therefore, a lessened rehospitalization rate and increased work productivity as a result (Herz, 1975).

If admission into a Day Hospital program follows a relatively short Inpatient hospital stay (to which I subscribe), it should have implications for better rehabilitation.

I conceive of Day Hospital as serving an additional function as a form of short-term crisis intervention in order to prevent the need for rehospitalization. Further, it could provide long-term treatment with and emphasis on social and vocational rehabilitation for chronic schizophrenic patients (Herz, 1975).

I also propose day treatment serving an extended family function and promoting mutual support systems. It can be a place where patients socialize together during the program day and carry this over on week nights and weekends. Thus, I advocate outside socialization in the expectation that these patients may help each other and thereby experience an enhanced sense of self-esteem.

An ideal Day Hospital program would have close liaison with community agencies which offer rehabilitation programs and sheltered workshops. Group solidarity should be stressed as a means of social rehabilitation (Herz, 1975). I believe that patient initiated and planned trips into the community, and social events would also be beneficial to facilitate group interaction and cohesion. The activities themselves could therefore become important as patients experience a sense of responsibility.

There are many advantages to the use of a day treatment program instead of Inpatient hospitalization, when possible. In dealing with schizophrenics who most frequently possess low self-esteem, it would appear that the very organization and stigma attached to hospitalization could contribute to a further degradation of self-esteem and worth. I postulate that the successful fulfillment of necessary roles, such as breadwinner, student, wife, mother, etc., would enhance the sense of esteem. Therefore, I contend that a Day Hospital program would be advantageous in maintaining these necessary roles while at the same time promoting effective treatment in this transitionary period. Thus, a day treatment program can additionally provide much needed socialization and rehabilitation for schizophrenics.

I propose then the development of a day treatment program with a provision for available weekend and evening care. I consider this treatment modality essential for effectively treating schizophrenics, and to be the main treatment modality whenever possible. I shall further develop this essential component of my envisioned program as I marshal the various therapies into an integrated treatment program. I propose that this program also encompass recreational and socialization occupational therapy, Dance Therapy and vocational rehabilitation. These all will be discussed separately and then integrated into a total program.

Outpatient and Aftercare

I consider Outpatient care necessary as an alternative to hospitalization and also as a support therapy after discharge. I consider an effective program of this nature should consist of supportive group therapy, and an activity program as necessary.

Aftercare is the continuing program of rehabilitation after hospitalization and is designed to reinforce the effects of therapy, and additionally, to help patients adjust to their environment (Herz, 1975). Often, patients are experiencing new living situations, new jobs and new family roles. An Outpatient or aftercare treatment could facilitate this adjustment.

In addition to individual therapy on an Outpatient basis, I conceive of an aftercare program to involve groups of patients with similar adjustment problems. This treatment could provide another example of an extended family-type of approach, and I consider it invaluable in effectively treating a schizophrenic patient population.

Recreational and Socialization Program

The objectives of a recreational and socialization program are: (1) to increase the personal growth of patients through the development of interpersonal relationships; (2) to alter self-attitudes by encouraging and supporting patients to gain self-confidence and a sense of security; (3) to aid in the development of new skills and interests; and (4) to redirect for-

mer behavior and the expression of basic drives into socially acceptable channels (Saint John's Hospital, Social Group Work Program, 1973). I envision this program as incorporated into a Day Hospital milieu setting.

The goal of this program is to create a comfortable and warm environment conducive to patient interaction and communication. Another goal is to elicit social and physical responses from each patient on the level at which he is capable of responding, and finally, to give maximum opportunity for the patient's self-expression and creativity in many different avenues (Saint John's Hospital, 1973). In this type of program, the activity itself is far less important than the kind of interpersonal relationships it engenders. Activities are spaced and interspaced to serve emotional, psychological and physical needs.

There is a great need for these types of therapies for schizophrenic patients in particular. They are often socially withdrawn, physically inactive, and in need of activities to assist their adaptation to life in the community. Herz, in his article, "Partial Hospitalization: Day Care and Night Hospitalization," states that many chronic schizophrenic patients are rehospitalized more as a result of their inadequate social and vocational capabilities than because of their pathology (Herz, 1975). Particular group activities are used to facilitate group interaction and cohesion. For example, activities such as planning trips into the community, serving and implementation of

meals provide patients ways in which group solidarity can be promoted and ways in which they can begin to take responsibility for themselves and each other.

Another problem with schizophrenics is their inability to experience and accept pleasure. A recreational and socialization program can train patients in the enjoyment of leisure time in various creative, athletic, intellectual and recreational activities which hopefully can be integrated as part of the lifestyle of these patients. For example, field trips into the community to expose patients to community resources, i.e., art museums, Y.M.C.A. programs, public gardens and places of interest can be helpful.

Many schizophrenic patients lack elementary life skills, so a socialization program which includes a relearning of these basic skills including shopping, cooking, personal hygiene, posture, social deportment, job hunting and dating skills would be of great value. I believe that participation in such group activities would lead to a sense of belonging. It would also serve as a stepping stone from the patient's total self-involvement to an involvement with others in a protective environment, and eventually to involvement with the social community.

I view a recreational and socialization program as helping to promote self-expression in a group setting, which may include expression of ideas, feelings, attitudes or values in a variety of verbal and nonverbal media. There are many activity-oriented groups which could serve the purposes of being diversional,

emotional, physical, vocational, avocational and social experiences. One of these could be a creative exercise group to help the patients become aware of muscles and tensions, as well as creative dance and movement to facilitate expression. Discussion groups could help to facilitate an intellectual experience. Drama groups could help the patients gain an awareness of their creativity, and perhaps even elicit spontaneity, as well as teach them how to become freer and more creative in expression of emotion and thought. Sing-alongs could serve as vehicles to create relaxation and group spirit. A cosmetology group could help awaken interest in personal appearance and hygiene. Walks, sports activities and even group games (i.e., bridge, poker, etc.) could foster a light sharing group spirit. Therapeutic activities such as art and music could promote self-expression and creativity. All these forms of recreational-social therapies could contribute to helping patients obtain new interests and strengths, as well as to explore their talents and interact in pleasant and constructive ways. Thus, I consider a recreational and socialization program to be an essential and much needed part of a comprehensively effective treatment program for schizophrenics.

Occupational Therapy Program

Occupational therapy is a method of treating the sick or impaired by means of purposeful occupation (Linn, 1975). The goals are to exercise the mind and body in healthy activity, overcome disability and arouse interest, courage and confidence,

thereby reestablishing capacity for industrial usefulness and social functioning (Linn, 1975). The occupational therapy assignment is fitted to the needs of individual patients and treatment is usually prescribed and administered with medical advice and correlated with other forms of treatment as part of the overall treatment program.

Group activities are usually preferred to facilitate the development of social skills and to enable patients to benefit from the example and encouragement of fellow patients. The initial assignment should take into account the patient's interests, skills and clinical state (Linn, 1975). For example, severely regressed patients might do well at first expressing their autistic thoughts and feelings in nonverbal terms, utilizing such media as finger-paints or clay. The idea essentially is to have this form of therapy be on a progressive continuum. For example, as patients improve, they go through steps such as making a useful object for someone, then perhaps accepting an assignment in a shelter workshop setting, next in a succession of increasingly autonomous working assignments until ready for discharge and for obtaining employment in the community.

The beginnings of Occupational Therapy involved a belief that activity, per se, was curative. Therefore, a search was made for specific tasks to cope with specific symptoms. For example, a depressed patient might be assigned to a task involving hammering, which was supposed to release pent-up aggression.

Then a shift in beliefs occurred with the primary psychiatric impairment found to be in patients' inabilities to relate to others. Thus, an effort was made to use Occupational Therapy to improve the quality of patients' relationships. This new point of view emphasises dynamically-oriented, therapeutic use of self. A working knowledge of psychoanalytic concepts such as transference and countertransference was developed and used in a therapeutic dialogue with the patients' nonverbal products, especially art, in order to reduce the intensity of irrational fears.

I have worked with Occupational Therapists in the team concept employed at Saint John's Hospital and found the art media to be extremely useful in understanding particular patients' inner worlds, and establishing a form of closeness while we painted, drew or sculpted together. I enjoyed the coming together of patient and staff member into fellow humans involved in similar tasks, that occurred in this type of therapy. There also was a chance to have fun and to share on a light-level of relating that I only experienced otherwise in the recreational activities I led. This form of sharing is important in my opinion, as it strengthens patients' confidence and is rewarded by actual tangible production of worth. Therefore, Occupational Therapy will also be an integral part of the total treatment program.

Dance Therapy and Nonverbal Body Ego Therapies

Dance Therapy is the planned use of dance to aid in the physical and psychic integration of the patient. The areas of treatment include behavior in which body-image disturbances constitute an important aspect of pathology (Linn, 1975). Dance traditionally is a means of expressing feelings, a method of communication and a healing force.

I conceive of Dance Therapy as a great help for the schizophrenic patient to utilize and to enjoy as part of a comprehensive milieu program.

The goals of Dance Therapy include: (1) an expression of affect; (2) heightening of body awareness; (3) reduction of idiosyncratic behavior; (4) fostering of interaction and communication; and (5) reestablishment of sense of self through movement (Linn, 1975). The means to these goals is rhythmic body action, revealing the patient's psychic state through movement patterns. Verbal imagery and music are used to further motor responsiveness.

Dance Therapy can be conducted in groups with the participants usually formed in a circle to promote a sense of unity and empathy. The therapist functions as a member of the group as well as an empathetic catalyst and a cohesive force in the overall structure. It is the patient's specific movement that the therapist seeks to recognize, analyze and treat (Linn, 1975).

Dance therapy, in contrast to the more verbal therapies, focuses on body movement to diagnose as well as influence

emotion and behavior. Dance therapists believe movement is not merely a manifestation of personality, but see it as an integral part of the personality, as well as a major influence on a person's emotional state (Feder, 1977). The focus is directly on physical change. Additionally, it assumes that the mind and body are inextricably interwoven. Thus, in Dance Therapy, patients' improvement is usually direct and observable, rather than inferential.

I contend that Dance Therapy is very well suited to aid in the treatment of schizophrenics since they often have an absence of self-synchrony (which is the relationship between body movement of a speaker and his speech patterns). Schizophrenics are often unaware of their own bodies, seeing themselves as disembodied beings. One goal of Dance Therapy is to increase patients' movement repertoire, and therefore, their ability to express moods, attitudes and ideas (Feder, 1977).

Schizophrenics literally may be confused about where their body stops and the external world begins. Dance Therapy could help them define the boundaries of their physical selves. An enlarged repertoire of body movements helps patients to express their own feelings and impulses and enables them to interpret more accurately the signals of others. For example, a handshake to a paranoid schizophrenic may be misinterpreted as an assault. Thus, an awareness of body communication could help to teach such a patient to recognize and interpret nonverbal messages more accurately.

Especially useful with schizophrenics is the ability of the body movement as used in Dance Therapy to bring patients' unconscious feelings to their conscious awareness. After this has been accomplished, I think the sensations, gestures and tensions must be recognized and interpreted. Once, while leading a movement and Dance Therapy group, a very severely regressed patient came into contact with feelings of wanting to be free and independent. The free form movement that had been adapted to classical music I was playing, allowed the patient to experience inner feelings and fantasies. At this point, the patient started to make more progress in individual therapy, and certainly started "becoming" someone who was able to cope more effectively. I therefore see Dance Therapy as valuable in the treatment of schizophrenics.

Many patients find dance an acceptable way to release suppressed emotions. Thus, a dance therapist could use set-patterned dances as nonthreatening introductions to cathartic movement (Feder, 1977). For example, simplified group dances such as Rumanian folk dances or the popular Russian "Hora" which involves vigorous foot-stamping, may help patients spontaneously express their violent and frightening emotions before they are able to do so verbally. To summarize, I believe Dance Therapy can have positive results in treating schizophrenic patients.

Vocational Rehabilitation

Vocational rehabilitation has been available through the State Department since 1943. It was then determined that every psychiatrically-handicapped person was entitled to help in job finding, vocational counseling and guidance, as well as vocational training (Linn, 1975). There are five interrelated services which are aimed at establishing and maintaining the patient in a job. The first is an evaluation of the client's (or patient's) abilities and interests. Vocational training is the second, and it involves enrolling the patient in a trade or professional school or arranging on-the-job training, which is paid for by the State Department of Vocational Rehabilitation. The third service is one of restoration and includes payment for medical, surgical or other treatments. Job finding and placement service provided by specific job-finding agencies is the fourth phase. Personal counseling is provided during the entire period of rehabilitation and follow-up until the occupational adjustment is complete.

I believe that it is very important for psychiatric patients (i.e., schizophrenics) to take advantage of such a program. As a therapist, I believe that this service can help complete the final postdischarge adjustment by helping the patient feel self-reliant again, successfully applying for and obtaining a job. Such a service could be included as an important and integral part of Inpatient programs, as well as really establishing a teamwork-type of approach by having, if possible, a vocational counselor available for feedback.

PROGRAM SUMMARY

Having discussed all the major components which I believe should be encompassed by an effective treatment program for schizophrenics, and developed an integrationary approach and an eclectic model, I would like now to marshal the elements and summarize the approach of this program.

I conceive of a Day Hospital setting as an extended family for the schizophrenic patient, providing support in times of stress and encouragement of growth and development in a somewhat protected setting. In my view, the environment should be as nonjudgmental as possible, constituting a setting in which the patient can be understood and accepted, as well as an environment conducive to the reflecting of his behavior.

I envision a staff of multidisciplines, comprised of Psychiatrists, Psychologists, Psychiatric Nurses, Psychiatric Social Workers, Occupational and Recreational Therapists, as well as available Dance Specialists and a Vocational Rehabilitation Counselor. These therapists must possess and display facilitative attitudes of empathy, genuineness, encouragement, concreteness and positive regard.

I believe that the Day Hospital should have its concentration on the here-and-now, permitting patients to experiment with directly stating their immediate needs and feelings. I conceive of the effectiveness of the approach as determined by its help to the patients' evaluations of their behavior in

terms of its effectiveness in getting what they want, and additionally providing new avenues of expression by means of a comprehensive therapeutic program.

I conceptualize the clinical content of a Day Hospital as a continuum of progressive interpersonal involvement. At one end of the continuum would be the extreme ambulatory schizophrenic withdrawal, and at the other end an involvement in life's warmth and intimacy, frustrations and joys. I believe the clinical program should be designed to provide growth experiences to lead toward more rewarding interpersonal relationships, based on more comfort with feelings of warmth and tenderness as well as feelings of irritation and anger. The therapeutic continuum of progressive interrelatedness would have extreme withdrawal at one end, and Occupational Therapy, Dance Therapy, drama and other groups, psychodrama or sociodrama, as appropriate, and socialization activities, group therapy and individual therapy as needed to lead to the goal of rewarding interpersonal relationships and effective behavior.

I believe that the focus should be on a socialization and activity program, as well as on the fostering of discharge planning, problem solving and social and occupational rehabilitation, in conjunction with pharmacotherapy.

I believe that Occupational Therapy should be an integral part of this program as it affords an opportunity for involvement with minimal verbal contact and offers an experience of starting to relate to people around such concrete objects as

art work, ceramics, etc. This part of the program conceivably could be the area in which occupational rehabilitation is also stressed. Another phase of Occupational Therapy could focus upon everyday living problems, such as budget planning, meal preparation and the introduction of new areas of interest.

A socialization program is a necessity in an effective treatment program for schizophrenics and should offer an extensive activity program to prepare the patients for community living. Activities such as group trips into the community to visit places of interest, drama, discussion groups and the like should be integrated into a comprehensive program. Physical sports activities and movement groups are essential in my eyes for the psychosocial rehabilitation of schizophrenics.

Group therapy should offer a verbal, affectual learning experience to the patient. I conceive of the staff as composed of members from various disciplines to facilitate communication among staff of an in-depth awareness of each individual patient. I believe that there should be several group therapies operating simultaneously, with patients selected for particular groups on the basis of which style would be most effective with them. Family therapy should be incorporated into this program and offer the patient an opportunity to deal with those introjected family members in a reality-oriented setting. I also see the need for a multiple family group so that the patient's significance to others can also have a place to receive support, encouragement and the knowledge that they are not alone in their

struggles. I see the need for the patient to have a primary therapist available at times he may need intensive one-to-one individual work, especially in times of crisis.

Medication management should be a primary part of this program and I conceive of a Psychiatric Nurse as taking over the actual foreseeing of the reduction of residual disabilities as well as overmedication symptoms. The prescribing of the appropriate medication must be done by a staff Psychiatrist who is open to feedback about dosage from other staff members.

I believe that the program set-up should be designed to maximize opportunities for staff intercommunication, primary (individual) therapist feedback, program evaluation and development and staff growth and development. These opportunities could be facilitated by several staff meetings conducted on a regular basis. I postulate that there is a need for a place to air emotional responses to patients, correct transference distortions, discuss clinical approaches and facilitate working together smoothly as a staff, as well as evaluating the program and developing new formats as the needs arise. I see this in addition to supervision of specific group therapies.

Discharge planning, in my opinion, must have its inception at the time of admission. I believe that a good approach might be one that looks at discharge as a graduation phenomenon, with sporadically planned alumni days in which all former patients would participate. In this way, the extended family concept is maintained as patients can return and visit. I maintain that

there is a need for an available primary therapist for patients' postdischarge as a means of crisis intervention.

Outpatient care must be initiated in the final portion of Day Hospitalization. A group therapy composed of discharged Day Hospital patients could maintain continuity as well as being a place to receive empathy, support and help in social and occupational rehabilitation. This type of group could also facilitate medication renewal and reiterate the common need to continue medication, despite apparent improvement in mental health.

I believe that aftercare arrangements must be investigated, and possibly, home visits made to ascertain the patient's home situation. I believe that there is a great need for more board-and-care home referrals as well as establishment of innovative aftercare places, as the current board-and-care homes now available are not in keeping with many schizophrenics' needs. For example, many board-and-care facilities do not offer adequate supervision, nor an adequate program to prevent the recurrence of withdrawal or behavior problems.

It is my opinion that there is a necessity for a continuity of care. For instance, a patient discharged from Inpatient care should be able either to go into a Day Hospital program or directly into Outpatient care until the adjustment is complete. All three modalities should, in my opinion, exercise a revolving door policy, so that the patient has appropriate services available to meet current needs. Community resources should be made known to patients, enabling them to take advantage of available

services. (For example: vocational rehabilitation; county welfare funding; and inexpensive community activities.)

In summary, it is my belief that a program such as I have described, combining pharmacotherapy with psychosocial therapies, would be effective. I believe that applying the extended family concept to all areas of community mental health would be of help, especially in lowering the recidivism rate.

III. CONCLUSION

My original hypothesis questioned whether the program which I envisioned would be needed, or might be utilized and effective in the treatment of schizophrenics. I have concluded that such a program would be effective, based on past studies. On the basis of the results from my questionnaire, I believe that it would be utilized. However, based on my visits to existing treatment facilities, I have not concluded that such a new program is needed in that it would add substantially to the similar ones extant. The therapist qualities to be encouraged in this treatment program would be effective and necessary ones for treating a schizophrenic patient population.

I have ascertained in the visits to facilities and in interviews with the directors of these programs, that there are few aftercare facilities available for postdischarge referral. I believe that this information dictates the need for the development of aftercare programs and facilities for the discharged schizophrenics to live in and in which to receive supportive therapy. I am further reminded of this need in a quote by Thomas Szaz,

> "If what we call 'suicide' is a cry for help, then what we call 'schizophrenia' is often a cry for housing." (Szaz, 1977)

To conclude, it is my belief that an effective treatment program for schizophrenics would include all three phases of treatment, including a comprehensive activity milieu Inpatient

program, when necessary, an effective Day Hospital program, focused on real-life problems, discharge planning, and social and occupational rehabilitation, and a comprehensive Out-patient program oriented toward support and rehabilitation. All three programs should combine pharmacotherapy and suitable psychosocial therapies to be effective.

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V. APPENDIX

TABULATED MASTER COPY

TO: THERAPISTS WORKING WITH SCHIZOPHRENIC PATIENTS

SUBJ: QUESTIONNAIRE - as part of Masters Thesis on developing effective treatment program for schizophrenics.

DIRECTIONS: Please circle as below with 1=Least Effective; 6=Most Effective
Please mail back in attached stamped envelope.

* THERAPISTS POLLED → (3) Psychiatric Technicians; (3) Psychiatric Social Workers; (3) Psychiatric Nurses; (1) Vocational Rehab. Counselor; (1) Psychiatrist - Out Pract.; (1) Marriage and Family Counselor / Pvt. Pract.

FACILITIES: Brotman Mem. Hsp. / Di Di Hirsch

YOUR OCCUPATIONAL TITLE OR FIELD

THERAPIST QUALITIES	EFFECTIVE→LEAST (Number of responses) →MOST					
Empathy	1 (0)	2 (0)	3 (1)	4 (1)	5 (3)	6 (5)
Respect	1 (0)	2 (0)	3 (0)	4 (2)	5 (2)	6 (6)
Positive Regard	1 (0)	2 (0)	3 (1)	4 (0)	5 (3)	6 (6)
Genuineness	1 (0)	2 (0)	3 (0)	4 (2)	5 (2)	6 (6)
Concreteness	1 (1)	2 (0)	3 (1)	4 (1)	5 (2)	6 (6)
Understanding	1 (0)	2 (0)	3 (2)	4 (3)	5 (2)	6 (3)
Dedication	1 (0)	2 (0)	3 (3)	4 (4)	5 (2)	6 (3)
Persistance	1 (0)	2 (0)	3 (2)	4 (4)	5 (2)	6 (3)
Tolerance	1 (2)	2 (0)	3 (0)	4 (4)	5 (2)	6 (3)
Firmness	1 (0)	2 (0)	3 (0)	4 (4)	5 (4)	6 (3)
Flexibility	1 (0)	2 (0)	3 (0)	4 (4)	5 (4)	6 (3)
Self-Disclosure	1 (4)	2 (2)	3 (3)	4 (2)	5 (0)	6 (0)
Encouragement	1 (0)	2 (1)	3 (1)	4 (2)	5 (0)	6 (6)
Others DIRECTNESS	1	2	3	4	5	6 (1)
CONSISTENCY	1	2	3	4	5	6 (1)
CONFRONTATION/REALITY TESTING	1	2	3	4	5	6 (1)

TREATMENT METHODS AND MODALITIES						
In-Patient Milieu Program	1 (2)	2 (0)	3 (1)	4 (2)	5 (2)	6 (3)
Day Hospital Program	1 (0)	2 (0)	3 (2)	4 (0)	5 (2)	6 (6)
Out-Patient Therapy	1 (0)	2 (0)	3 (2)	4 (2)	5 (2)	6 (4)
Home Care	1 (2)	2 (0)	3 (2)	4 (2)	5 (3)	6 (2)
Individual Therapy	1 (0)	2 (0)	3 (1)	4 (2)	5 (4)	6 (2)
Group Therapy	1 (0)	2 (0)	3 (1)	4 (0)	5 (4)	6 (4)
Family Therapy	1 (0)	2 (0)	3 (0)	4 (0)	5 (5)	6 (4)
Anti-Psychotic Drug Therapy	1 (0)	2 (3)	3 (0)	4 (0)	5 (0)	6 (5)
Electroconvulsive Therapy	1 (6)	2 (2)	3 (2)	4 (0)	5 (0)	6 (0)
Megavitamins	1 (7)	2 (0)	3 (2)	4 (0)	5 (0)	6 (0)
Psychosurgery	1 (0)	2 (0)	3 (3)	4 (0)	5 (0)	6 (0)
Behavior Modification	1 (0)	2 (0)	3 (3)	4 (2)	5 (3)	6 (3)
Psychoanalysis	1 (4)	2 (0)	3 (3)	4 (2)	5 (0)	6 (3)
Laingian-Existential Approach	1 (4)	2 (0)	3 (4)	4 (2)	5 (0)	6 (2)
Occupational Therapy	1 (0)	2 (0)	3 (2)	4 (3)	5 (2)	6 (4)
Recreational Therapy	1 (0)	2 (0)	3 (2)	4 (3)	5 (2)	6 (5)
Socialization Program	1 (0)	2 (0)	3 (0)	4 (2)	5 (2)	6 (3)
Vocational Rehabilitation	1 (0)	2 (0)	3 (0)	4 (2)	5 (2)	6 (2)
Dance Therapy	1 (3)	2 (0)	3 (3)	4 (2)	5 (1)	6 (0)
Psychodrama	1 (3)	2 (0)	3 (2)	4 (2)	5 (2)	6 (0)
Eclectic Therapies	1 (0)	2 (0)	3 (2)	4 (2)	5 (2)	6 (0)
Sensory Awareness Groups	1 (3)	2 (2)	3 (0)	4 (2)	5 (1)	6 (0)
Others CRISIS INTERVENTION	1	2	3	4	5	6 (1)
AID TO DAILY LIVING	1	2	3	4	5	6 (1)
RESTRAINTS	1	2 (1)	3	4	5	6

COMMENTS: (None)

SCHIZOPHRENIA AND ITS THEORETICAL ETIOLOGIES

(Portion of a previous paper on Schizophrenia)

Schizophrenia is a common mental disorder and accounts for up to 30% of all admissions to psychiatric hospitals. According to the National Institute of Mental Health, it now ranks as our Number One mental health problem and an estimated $5 billion is directly spent on care.[1] Over half of all mental hospital beds are occupied by schizophrenics, and in the U.S. the estimated incidence of schizophrenia is about 1% of the population.

Despite these overwhelming statistics, there has not been that much progress made as far as causation or treatment. In order to intervene and treat this mental disorder, I feel that it is necessary to first know about the nature of the disorder and how to identify it. Then one can have a better handle on deciding at which point to intervene, how to intervene, and what method to use most effectively at eliminating or mitigating it or even just arresting its progress. I will attempt to clarify these necessary prerequisites to intervention in a systematic process, as possible, starting first with the various diagnostic criterions involved.

Scientific study of this disorder began in the 19th Century when Benedict Augustin Morel introduced the term "demence precoce," which for Morel, was a hereditary disease that led

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[1]Knox, Gerald M., "Schizophrenia," in *Better Homes & Gardens*, March, 1976.

to deterioration after its first appearance in the adolescent years. Morel made his observations in 1860 of intellectual and personality deterioration in a supposedly normal 14-year-old boy, and this was taken as sufficient proof that dementia could appear at a young age and therefore must be inherited. In 1868, Kahlbaum described a condition he named "katatonia," referring to strange motor disturbances. Hecker, in 1870, coined the term "hebephrenia," to characterize a condition of silly regressive behavior.

Emil Kraepelin, who did much work in classifying mental illnesses, used the term "dementia praecox" in 1898 to emphasize the deterioration of certain aspects of mental functioning and also to describe its usual onset in adolescence. Kraepelin essentially seems to have unified the previous three conditions, and additionally identified three subtypes: paranoid, catatonic and hebephrenic. Kraepelin considered them to be organic illnesses even though they were described in psychological terms. He felt that the fundamental disturbance was in affect, with an impoverishment of feelings and interests with no impairment of the ability to understand and remember. Along with his work on schizophrenia, Kraepelin contrasted this with the development of what we now call the major affective illnesses, in which the primary disturbance was either a depressed or elated mood.

A fourth subtype of schizophrenia was added in 1911 by Eugen Bleuler, who enlarged the concept described by Kraepelin

to include milder cases which did not show any of the florid signs of the condition or marked deterioration. He coined the term "schizophrenia," which meant divided or split mind and also signified a disorganization of the self. For Bleuler, schizophrenia was less a physiologically degenerative and deteriorating illness than it was a disturbance of the capacity of association and an autistic retreat from reality; including symptoms of disturbances in association, affect, ambivalence and autism.

The American Psychiatric Association states that schizoprenia is a group of disorders "manifested by characteristic disturbances of thinking, mood and behavior. Disturbances in thinking are marked by alternations of concept formation which may lead to misinterpretation of reality and sometimes to delusions and hallucinations, which frequently appear psychologically self-protective. Corollary mood changes include ambivalent, constricted and inappropriate emotional responsiveness and loss of empathy with others. Behavior may be withdrawn, regressive and bizarre." [1]

The cognitive symptoms are: (1) disturbances of language and thought; (2) distortions of the body image; (3) a retreat from reality to fantasy; (4) hallucinations; (5) delusions.[2]

The symptoms of social withdrawal are: (1) fear of others; (2) avoidance of relationships with others; and (3) isolation from others.[2]

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[1] *Diagnostic and Statistical Manual of Mental Disorders*, DSMII, APA 1968.

[2] Sheahan, Joan, "Essential Psychiatry for Nurses," MPT, 1973.

There are several types of schizophrenia with varied and often contrasting behavior patterns. To summarize the types most efficiently, I will deal only with the major symptoms of each. The simple schizophrenic is usually apathetic, seclusive and withdrawn from society. The hebephrenic usually leads a life of minimal attachment to society and breaks completely with our conception of reality by becoming delusional, hallucinatory and incapable of communicating with others. By contrast, the catatonic deals with his intense anxieties by making himself immobile and "freezing" while trying to figure out which move to make to solve his conflicts. The paranoid stays involved with the real world, but does distort his reality by becoming suspicious, resentful and hostile with a rather irrational quality to his responses.[1]

There have been several other types of schizophrenia which have been added to the classic four described above. The Acute schizophrenic episode has a sudden onset of symptoms (as contrasted with simple schizophrenia) usually associated with confusion, ideas of reference, emotional turmoil, dreamlike dissociation, depression, fear and perplexity. The schizo-affective type combines many of the general symptoms but has a more pronounced obvious elation or depression. The childhood type has symptoms which appear before puberty, often developmental defects which can result in mental retardation; showing a marked

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[1]McNeil, Elton B., *The Psychoses*, Prentice-Hall, New Jersey, 1970.

preoccupation with fantasy. The latent-type lacks a full history of full-blown schizophrenic episodes. There is also the residual type which frequently appears in remission following a schizophrenic episode; and the chronic undifferentiated type which although manifesting symptoms in thought, affect and behavior, is not classifiable under the other types.[1]

There has been much extensive research done in the field of schizophrenia searching for a cause. So far, there seem to be theories dealing with biological, psychological and social causation. Since there have been so many studies on almost every possible aspect, I shall deal briefly with those that seem to be the most universally accepted.

Many investigators have explored the possibilities that genetic factors may play an important causal role in schizophrenia , due to the disportionate incidence in the family backgrounds of many schizophrenic patients. Twin studies were designed to test the concordance rates for identical versus fraternal twins and did not show that the schizophrenia rate for identical twins is over thirty times greater than expected in the general population. However, there apparently is even a greater discordance rate for schizophrenia in identical twins, which essentially means that schizophrenia is not solely the result of genetic factors. There have also been numerous studies done trying to eliminate the possible causal influence of being

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[1]Coleman, James C., *Abnormal Psychology and Modern Life*, 1976.

raised by schizophrenic parents. The results shown in 1966, in the study done by Heston, showed that 16.6% of the subjects who had been born to schizophrenic mothers in a State mental hospital and placed in foster homes or with relatives shortly after birth, were they themselves diagnosed as schizophrenic. Heston concluded that children born to schizophrenic mothers, even when reared away from them, were more likely to either become schizophrenic or even to suffer from other disorders such as mental retardation, neurosis, sociopathic and even to be frequently involved in criminal activities.[1]

Research has also been done on the possibilities of children becoming schizophrenic when reared by their schizophrenic parents. Rieder (1973) found a wide variety of psychopathology reported with adult offspring of schizophrenic parents; 20% of psychological maladjustments as children including withdrawn schizoid-type and hyperactive, delinquent, asocial types being the most prominent. Also, there have been studies done to attempt to identify children who would be considered high risks to later develop schizophrenia. The children with schizophrenic mothers; children who show a history of serious birth difficulties; children who show unsocialized behavior which may include extreme aggressiveness; and children who are exposed to aversive sociocultural environments; these are the four groups of children considered most likely to develop schizophrenia.[2] But,

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[1] Ibid., Page 311.

[2] Ibid.

since these studies have not been completed yet, it still is unknown whether these factors really do determine the development of schizophrenia.

Meehl, in 1962, combined a single theory encompassing both genetic and neural aspects. He stated that there is an inherited defect in the nervous system which predisposes the individual to schizophrenia when also coupled with an unfortunate early psychological environment. Therefore, the more severe the inherited defect, the milder need be the environmental stress to trigger the schizophrenia. With this theory, however, it is necessary to demonstrate the precise manner which the trait is passed on to the next generation; then the prevention could be done through eugenics, which is preventing people with even a taint of schizophrenia from having children.[1] There have also been numerous studies of the possible etiologies of schizophrenia including: recessive genes (Kallmann, 1953); dominant genes (Book, 1953); different genes causing each subgroup of schizophrenia (Weinberg and Lobstein, 1943); too much serotonin, a brain neurohumor (Woolley, 1962); a faulty oxidation of adrenaline interfering with brain functioning (Hoffer and Osmanond, 1959); imbalance between sympathetic nervous functioning and parasympathetic nervous function (Rubin, 1962); an amine found in the urine of many schizophrenics called dimethyloxyphenylethamine, which produced the "pink spot test."

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[1]Buss, Arnold & Edith, *Theories of Schizophrenia*.

Studies have also been done of the effects of injecting taraxein (a substance in the blood of schizophrenic patients) into nonschizophrenic volunteers, which produced schizophrenic-like symptoms including thought blocking, disorganization and fragmentation of thought-processes, delusions, hallucinations and feelings of depersonalization. This experiment was done in 1957 by Heath, and the conclusion reached was that there was a metabolic defect in schizophrenia which may be inherited that is activated by severe stress. Heath also postulated that the body manufactures antibodies that act against its own brain cells in schizophrenia.[1] Even more studies have been done involving the study of the nailfold capillaries of schizophrenics; the theory that schizophrenics have an abnormally excitable nervous system, faulty brain transmission at synapses at brain cities; altered levels of certain chemicals in the brain which affect mood or carry impulses from sensory to motor neurons; too much Dopamine and quite a few other theories centering on a biochemical cause of schizophrenia, none of which have been totally conclusive.

As far as psychological and interpersonal factors as a causational factor in the development of schizophrenia, the research primarily centers around the theories of early psychic trauma and increased vulnerability, pathogenic parent-child and family interactions, exaggerated defenses and faulty learning,

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[1]Coleman, James C., *Abnormal Psychology and Modern Life*, 1976.

destructive social roles and interpersonal patterns and also with excessive stress and decompensation.[1] Children frequently use denial and repression to deal with their traumatic experiences and this may cause damages to their defense systems, as they may begin to set up fantasies, while at the same time try to get approval. Many studies have been done on the parents of schizophrenics; the typical mothers are characterized as rejecting, cold, overprotecting, dominating and impervious to the needs and feelings of others. At the same time, this type of parent depends on the child to meet their needs and this child does not develop his own sense of identity. They provide bad role models and apparently use the child in their poor marital relationship. The studies done also indicate a somewhat indifferent, passive and inadequate type of father who is also insensitive to others' needs and feelings and is rejecty toward his son and seductive toward his daughter. At the same time, the father is derogatory toward his wife, which forces her into competition with her daughter, and devaluates her as a role model for the daughter; the daughter begins to hate her and feels incestuous feelings toward her father. With this type of neurotic family situation going on, it is little wonder that there is a high incidence rate of emotional disturbances on the parts of both mothers and fathers of schizophrenics.

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[1]Ibid., Page 317.

Lidz (1957) describes the "marital schism" as the chronic undermining of the worth of one marital partner by the other, giving a clear message to the child that they do not respect or value each other; and additionally even expressing the fear that the child might resemble the other parent and then both end up by rejecting the child. The "marital skew" is described by Lidz as being maladapted behavior of the family members being accepted as normal. The results of these studies showed that male schizophrenics usually came from "skewed" families with ineffectual, passive fathers and engulfing, disturbed mothers with at least one parent being seriously disturbed and lots of reality distortion in the families. Children also may receive conflicting messages from their parents; they are claimed to be loved but are handled without warmth. This creates a great deal of anxiety in the child who cannot deal with this type of double-bind and becomes anxious, which can ultimately lead to the beginning of fragmented thinking. Children are also off to a bad start when they grow up in a family where putting each other down is more common than praising each other; this is often the time when the child begins to develop a very poor sense of self-worth. Also, these children may be part of a family which needs a sick or problem member to exist; or a part of a family relationship which gives the appearance of being open, mutual and understanding but is not (coined as pseudo-mutuality by Wynne 1958); or the family role structure may be

extremely rigid which tends to depersonalize the child and block his growth toward self-direction and maturity, as Coleman has stated.

A prominent symptom of schizophrenia is social withdrawal with characteristics of shyness, seclusiveness and a preference for solitude. Farris (1934) feels that the child is pushed aside and isolated by the very community in which he lives, which eventually leads to a shut-in type of personality. The individual slowly turns away from social contacts and no longer even bothers to test his reality against social consensus. As his social distance from others increases, he orients his attention more and more toward himself, especially with his fantasies and his body. This type of individual fails to develop any semblance to normal social roles or adequate communication skills. He remains outside the mainstream of everyday life and eventually drifts into schizophrenia. As in all of the above studies on children, the crucial evidence must come from a longitudinal study that traces the development of schizophrenia from childhood to the onset of psychotic symptoms.[1]

There is also a regression theory to explain the development of schizophrenia. Both psychoanalysis and the comparative developmental approach assume that there are fixed stages in the developmental sequence. This essentially means that each child must master the problems of a given stage and then proceed to

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[1]Buss, Arnold & Edith, *Theories of Schizophrenia*.

the next stage, with the end point of the sequence being maturity and normality. When an adult moves back to an earlier stage as shown by his behavior modes, this is called regression. Regression causes immaturity and abnormality and the severest regression presumably causes the severest abnormality - schizophrenia. Kantor and Winder (1959) elaborated the theory of Harry S. Sullivan and related his five stages of early childhood to the process-reactive dimension of schizophrenia. They imply that the infant must be nurtured and loved, for disapproval and rejection are likely to lead to fixation and subsequently to a schizophrenic regression. Again, this study must be done on a longitudinal basis to be accurate.

Another approach to explaining the etiology of schizophrenia focuses on excessive anxiety. One possibility is that the potential schizophrenic is abnormally sensitive to criticism and rebuff; Garmezy and Rodnick in 1959, came up with a social censure hypothesis which assumes that the schizophrenic's heightened fear of rejection causes him to be inefficient and drives him into a self-imposed isolation from others. Mednick (1959) takes this one step further and makes the assumption that the potential schizophrenic's high anxiety serves as an irrelevant and interfering drive, and this accounts for the thinking disorder present in schizophrenia. Mednick first assumes that the schizophrenic is extremely anxious and then that high drive or high anxiety leads to overgeneralizations. With more and more stimuli becoming frightening, the individual

is driven to avoid the stimuli. The individual then escapes by thinking of remote and irrelevant thoughts and associations which distracts him from anxiety-producing thoughts, and in this way reduces his anxiety level. This reduction in anxiety is rewarding and then the tendency to think distant and irrelevant thoughts becomes habitual. According to Buss, there is conflicting evidence on Mednick's theory and a longitudinal study following schizophrenics from the earliest sign of the psychosis until its chronic stages would tend to prove or disprove this theory.

After doing extensive research into finding even one valid causal factor for schizophrenia, I must conclude that it is my feeling that the etiology must come from a combination of factors including biological, familial, social and psychological. Until studies are done on a longitudinal basis and can be validly proved, I think the focus must be on intervention and treatment, which I now shall attempt to cover.