PSYCHOTHERAPY OF CHRONIC SCHIZOPHRENIC PATIENTS

SEA ISLAND CONFERENCE

Psychotherapy of Chronic Schizophrenic Patients

EDITED BY

Carl Whitaker

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Psychotherapy of Chronic Schizophrenic Patients

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Publisher's Note

I first met Carl Whitaker and Tom Malone, who later collaborated on a successful book,* in 1953. The friendship we began then has remained steadfast.

Early in 1955 Carl told me that for eight or nine years he and a small group of psychiatrists had met annually to exchange ideas concerning the diagnosis and treatment of the schizophrenic patient. He felt that they had at last become articulate to the point of communicating with each other.

Out of their next conference this document was born. The meeting took place on October 15, 16 and 17, 1955, at the King and Prince Hotel, Sea Island, Georgia. A new member of the group was the brilliant anthropologist Gregory Bateson—a wise addition, as readers of this book will agree. His intellectual approach and perception of the problems add much originality to this report.

There were eight sessions (and a summing up session, which appears in this book only in the form of short summaries after the chapters), each moderated by one of the participants. The agenda was carefully planned, and each member of the group was assigned in advance the topic for his session.

This was no ordinary symposium as we know the term in medical circles—a reading of unrelated papers on a general subject, followed by general discussion. This was a coordinated,

* Whitaker, Carl A., and Thomas P. Malone, *The Roots of Psychotherapy,* Blakiston Division, McGraw–Hill, 1953.

planned conference devoted totally to discussion, with no papers, no formal presentation of material. Each session considered a significant aspect of the diagnosis and treatment of the schizophrenic patient, and each session logically followed the preceding one.

Every word of the conference was taken down by stenotypy and was tape-recorded. The material was edited by each member but not rewritten. There is no second-guessing in this report. It is a valid document of a unique experience. It has direction and confidence.

It should be stated that all of the group are primarily interested in the psychotic patient as opposed to the neurotic patient. Furthermore, they use psychotherapy exclusively. The material gains in significance and strength because during their previous meetings they recorded their discussions, but only for their own enlightenment. Not until this conference had publication been considered.

Much has been said and written concerning the schizophrenic individual and his family. I believe that this book in an extraordinary way contains the elements which brilliantly point the way to future understanding of one of the most difficult problems in human relationships today. I proudly recommend it to you, the reader.

THEODORE A. PHILLIPS, *Manager*
Medical Book Department
Little, Brown and Company

Introduction

This book is neither a didactic lecture nor a symposium covering unrelated problems. It grew from an effort to communicate in a largely uncharted area where knowledge is too extra-verbal to fit our usual word patterns — an effort by a peer group to discuss problems in the diagnosis and treatment of chronic schizophrenics. It grew out of the contributors' belief that people communicate more to one another than they can say. It is of course gratifying to us for a publisher to sponsor such an effort, and evidence his belief that there is more to words than the sum of their individual meanings.

We wanted to agree on some concepts, to discover new disagreements, to destroy some clichés, and perhaps to spawn some new ideas. We agreed, for example, that one central problem is to unleash the psychosis rather than to develop social adequacy, and we agreed in a general way that "replacement therapy" is only a single aspect of therapy. Love is not enough. The therapist's "feeding" experience with the chronic schizophrenic patient does not suffice, although some of us believe that treatment is ineffective without it.

In the book we are talking to one another rather than to the reader. I profited from this meeting by talking to men who challenged me to say things I suspected I knew but somehow could not express either to myself or to impersonal colleagues in the same field. The therapist is ill prepared, even by his own experience as a patient, to evaluate his professional function while

working with the schizophrenic patient. And the treatment process is much too extra-verbal for even the technical vocabulary, and much too personal to be shared casually even with other psychiatrists. To sharpen our functional effectiveness, it is therefore necessary to bang our experience against that of other psychiatrists with similar experience and with the drive to push the limits of communication.

Each author speaks only for himself, although the editor is responsible for inaccuracies or misquotations. The chaff has often been included with the grain because we feel that subtle points become apparent between the lines.

Psychopathology is now of age; psychotherapy, its stepchild, is in its adolescence. Present-day therapists are freer of their own pathological stumbling blocks because they have profited from better patient experience and supervised casework in their training. The experienced therapist is pushed beyond "just listening." Play therapy and group therapy, for instance, break the tyranny of words and minimize his isolation as a transference object. Moreover, we are now developing a nomenclature applicable to the schizophrenias rather than to the neuroses. These new developments have encouraged the therapist to treat "incurable" schizophrenics.

As psychotherapy matures, a conviction is evolving that schizophrenic patients can recover. In fact, schizophrenia may be to some extent a wave analyzer of the pathology in our culture and in the therapist's own social adaptation. During treatment these experts at receiving interpersonal signals might help us see ourselves as others "sense" us.

Do we sound like art critics trying to describe rationally our bizarre, irrational relationship with the psychotic? How can I rationally describe my experience when a psychotic to whom I was profoundly attached made a negative hallucination of me? I became invisible to her; my reaction was panic. Did I really exist or was she right?

In this book each contributor speaks in terms of his own experience rather than of accepted theory. The double-bind hypothesis regarding the etiology of schizophrenia was presented to clinicians for the first time at this symposium. In essence it is a resynthesis of his personal experience by an expert in communication.

This book will be useful primarily to psychiatrists who treat schizophrenic patients, whether they work in centers for research, in mental hospitals or in private offices. But it should also interest the behavioral scientists and indeed all who are interested in schizophrenia as an index of human potentiality, as a type of perception inferring and implying much about the spectrum of humanness. This book should affirm for the student of psychiatry that the most extreme cases of psychopathology can be reached. The medical student must learn to think outside the realm of textbook knowledge. Perhaps the book is valuable to him as an intimate view of how explorers on the edge of knowledge become confused and achieve clarity, get into arguments and achieve agreement.

This book has been edited by each contributor and by an editorial committee composed of the contributors in Atlanta. To John Warkentin for his straight thinking and bursts of intuition and to Tom Malone for his conceptual clarity and sure decisiveness go a major part of the credit for processing the individual sections into a readable whole. Thanks also to my patients for demanding increased sensitivity and for being intolerant of any fixed ideas of their schizophrenic struggles. To Virginia and Linda and Muriel, who defended the home front during long evenings, we return to celebrate being together again. To Sarah Davis for endless typing and to Little, Brown for Ted Phillips go our thanks.

CARL WHITAKER

Contents

Psychotherapy of Chronic Schizophrenic Patients

Chapter 1

Diagnosis and Prognosis

Moderator: MALCOLM HAYWARD

ORIENTATION

The group decided that it was important to clarify the diagnostic terms used among ourselves, in order to make ourselves clear to others. Over the years, as we have come to know each other, we have become accustomed to speaking of a patient as being "very sick" or "fairly sick." These evaluations are based chiefly on prognosis and "treatability," since the Kraepelinian objective descriptive terminology has proved to be of little value for us in sizing up a patient.

In an evaluation, therefore, we have a tendency to include some opinion as to the patient's ability to relate and respond to the therapist: "This patient looks pretty darn sick, but he's ready for therapy" versus "This patient doesn't look sick, but I think you'll find that he's going to move very slowly."

We felt it essential to try to clarify for the reader what factors we consider important in making an evaluation. But the reader is warned that the group is chiefly interested in therapy, not in pigeonholing and categorizing. As Jackson put it, "Among the people I have treated is one who was hospitalized for seven years and didn't speak to anyone for two years, and who didn't speak to me for three months, and whom I saw six days a week. I don't think of that patient as much different from some-

one who walks into my office and says, 'Look, I am crazy.' Even granting some difference, the total experience is similar. It's on this that we should focus."

DISCUSSION

Whitaker: There is a problem right away in terms of the demands of the culture on the schizophrenic. Is schizophrenia a reaction to this threatening demand? As we have all seen, if a proper environment can be set up for the schizophrenic, he often becomes less bizarre, or what we call "sick." As I see it, we have got to struggle with the idea of the demands of the culture; and also the evaluation of what is needed to save the patient's ego.

Rosen: I wish to interpose an objection. I don't think it is our business to discuss cultures in which the understanding of schizophrenia is, let us say, no farther advanced than that of a medicine man. It is already difficult to communicate with each other, without discussing cultures. We want to be sure that we understand the different categories of cases that come under the heading "Schizophrenia — Chronic and Acute." Otherwise it could be confusing.

Bateson: I think that one of the things that need to be said in relation to the culture is that many schizophrenics get a lot of secondary gain out of schizophrenia, and do fit into society. There are schizophrenics who make certain gains clinically, and this medicine-man argument applies just as much at home as abroad.

Rosen: But that may be confusing if we are not clear among ourselves about the categories of patients.

Whitaker: Can we use the term "socially decompensated" to simplify the categories?

Hayward: When do we start calling a person a "clinical schizophrenic"?

Whitaker: Isn't it when he is socially decompensated to the point that he can be damn sick, and needs help either clinically or by some other method? Practically, we deal with the ones who are socially threatened to the extent that they have become decompensated.

Rosen: Keep going, and when we get into a difficulty, we can clarify.

Malone: When you talk, John, you imply that somehow, in the back of your head, you have certain categories of this disease that are useful to you clinically.

Rosen: That is not true. I have a general idea of what I am thinking about. I should like to divide sick people into two big categories — more neurotic or more psychotic. I should like to draw a distinction there, so that we can understand better what we mean by ambulatory, or perhaps compensated. Really, any schizophrenic is compensated. His symptoms are his compensation. If you want to bring in a little theory, perhaps we ought to understand that everybody is "schizophrenic," in the sense that schizophrenia means that you have an unconscious which operates in you, and that if that unconscious dominates your conscious self sufficiently to make you function without judgment, then I think you can talk about being sick. Do I make myself clear?

Whitaker: Excepting "without judgment." "Without judgment" to me is merely another way of defining "without proper social persuasion."

Rosen: Fine. But if a man thinks the FBI is after him, he has no judgment and you can forget "social persuasion."

Bateson: He has specific judgment — the judgment of the unconscious.

Rosen: The unconscious has no judgment whatsover. The red blood cells do not even distinguish between oxygen and carbon monoxide.

Jackson: Your system is functional, and in one sense it is out-

dated. The FBI man is not a reason for judgment, but it's an effect that you are trying to create.

Rosen: I know about that. I am not limiting the situation. What I am trying to do is to broadly express an idea, and then — if it is possible — pinpoint it. I think we can work on that instead of going off into a discussion of what would be considered schizophrenia and what would be considered culture.

Hayward: Should we start with clinical groups?

Jackson: Can we change from "schizophrenia" to "schizophrenic patients"?

Rosen: I think that term is confusing. Let's talk about "psychosis" instead.

Jackson: All right, I will buy "psychosis."

Taylor: Is "psychosis" more inclusive than "schizophrenia"?

Rosen: It is the degree. First a broad category of "mental illness," which means a "loss in adaptability." We call all one type of people neurotics. Then we take leave of that type of sickness and call all of these other types of person pyschotic, bearing in mind always that every neurotic has a psychosis, because "psychosis" only indicates to what extent the conscious is inundated by the unconscious, which is where all psychosis comes from.

Whitaker: We are pretty much in agreement about this.

Rosen: Maybe we are now, but you meant something when you mentioned the type of culture. Maybe I don't understand what you are trying to pinpoint — what you are saying. Maybe it does apply, and I would like to be enlightened.

Hayward: It would help us to get first a set of clinical criteria, so that we can all agree what we are talking about. I think that if we first can agree about the historical background of what we are talking about, we might be on the right road.

Warkentin: Kraepelin* seems to have thought of schizophren-

* Kraepelin, E., *Lectures on Clinical Psychiatry,* William Wood, New York, 1917.