Enabling Conditions for the Ambulatory Psychotherapy of Acute Schizophrenics

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e-Book 2018 International Psychotherapy Institute

From *Specialized Techniques in Individual Psychotherapy* edited by Toksoz B. Karasu and Leopold Bellak

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The psychotherapy of acutely disturbed schizophrenics can be one of the most rewarding of therapeutic experiences. It is frequently possible to effect a dramatic loss of symptoms and general improvement of the acute manifestations of the disorder rather promptly. It often enough holds true that after the acute phase has been successfully dealt with, there remain the characterological features which are of complex nature and that often require prolonged and patient treatment. The present discussion, however, addresses itself only to the circumstances necessary for the treatment of the acute phase of a schizophrenic episode.

Certainly, the first question that must arise in the treatment of an acutely disturbed psychotic on an ambulatory basis, in the private office, social agency, or a clinic, must be whether a patient is suitable for this type of treatment.

Therefore, I want to address myself to the necessary conditions, the conditions that enable one to perform ambulatory psychotherapy with acute schizophrenics. If the enabling conditions outlined cannot be met, ambulatory psychotherapy may not be advisable, and an alternate mode of treatment may be indicated.

1) A Reasonably Cooperative, Non-assaultive Patient

One of the most obvious enabling conditions is that one has to have a *reasonably cooperative, non-assaultive patient.* By reasonably cooperative, I mean that he at least comes to the session or is willing to be brought by a third party. However, it may be possible to start psychotherapy with a patient who is

unwilling to come to therapy. Sometimes it is necessary to visit the patient in his own home, at least to initiate therapy. When this is not possible or feasible, an effective means of getting an unwilling patient to the office is to instruct a family member to ask the patient to accompany him to see the psychotherapist for his—the relative's—own sake. It is usually true enough that the relative is deeply concerned and upset, and is being sincere when he tells the patient that he wants some help for dealing with some of his own problems. Often the patient is then willing to come along as a mute companion. The initial exchanges are all between the therapist and the patient's relative. It must be part of the therapist's skill to eventually engage the patient until he or she slowly becomes the main interactor and ultimately the sole one.

One other possibility of engaging a patient in treatment, if the above procedure is ineffectual, is to engage in *mediate interpretations.* If a patient refuses to come by himself or even with a companion, as described above, it may be possible to learn enough about the psychodynamics of the patient from the relative to suggest statements or interpretations which the relative can then relay back to the patient. If, in turn, the relative reports back to the therapist, he can be used to mediate the therapy in such a way that the patient might be affected beneficially enough to a point where lie is willing to come for treatment with the relative as companion. Then the therapist can proceed as above.

The fact that many schizophrenics may start out mute or barely communicative is no contraindication to therapy. Even potential assaultiveness need not be a contraindication, provided one sets up certain conditions which I will discuss later, with regard to certain precautions and the possible concomitant use of drugs. Of course, I include patients in ambulatory psychotherapy who are often actively deluded and hallucinated. Most of us are aware of the fact that in many patients extensive delusions and hallucinations need not necessarily interfere in seemingly normal social behavior. There is many a patient who thinks he is Jesus Christ or believes he can understand what the birds are saying, but nevertheless may continue to hold a skilled job and

arrive punctually for each of his appointments. Although some patients may not be well enough to come on their own by car or bus, they may still profit from ambulatory psychotherapy, if someone brings them to the therapist's office.

The premise is that, whenever possible, it is better to avoid hospitalization, provided the patient is not actively homicidal or suicidal or so disturbed as to do harm inadvertently. The fact is that very little competent psychotherapy is offered in any hospital. In university-affiliated institutions, residents are usually the ones directly treating the patient, even though under supervision. Though they may be competent, the fact is they are still at an early stage of their training. In private institutions, there are usually not enough psychotherapists available, or else the therapists available are of questionable competence. The cost of hospitalization often approaches $100,000 a year. In addition, regression and secondary gain from being cared for ("nursed") produce other problems. Very frequently, the patient's reentry into the community, if it is not extremely skillfully handled, starts a new flare-up.

2) One Stable Relationship in the Patient's Life

Less obvious and less generally considered is the almost absolute need for at least *one stable relationship in the patient's life situation*—at least one person, such as parent, spouse, child, close friend—anybody whom one might turn to if the circumstances should warrant it. The therapist must be able to talk to somebody who is willing to keep an eye on the patient at home, because of concerns about suicide, or other potentially harmful situations; someone who can take a helpful role if the patient should require hospitalization, or can otherwise serve as a constructive influence in the patient's life. Without at least a single stable person close to the patient, I have found through bitter experience that one may be left with almost impossible situations, more responsibility than one can reasonably handle, and with less safety than is essential for the treatment situation.

3) A Close Relationship with a Nearby Hospital

The third enabling condition for anybody who wants to treat rather acutely disturbed psychotics is that one have a *close relationship with a nearby hospital,* including a general hospital willing to take psychiatric patients. It is essential in treating acute psychotics that one be willing to take reasonable risks. Those reasonable risks include the possibility that some patients will become more disturbed in the course of treatment, either for adventitious reasons or for reasons intrinsic to the treatment.

The therapist can engage in psychotherapy with acutely disturbed people only if he feels safe enough. He needs an arrangement which permits almost instant hospitalization of the patient, should the need arise. At times, even only two or three days of hospitalization can make a crucial difference. This provision certainly helps to give one more therapeutic freedom with less anxiety for patient and therapist. The hospital provides some immediate protection for the patient and gives the therapist freedom to engage in interventions which might possibly be upsetting to the patient.

Though therapeutic freedom sometimes has to include interventions which might prove unnerving to the patient, I do not believe in inducing regressions intentionally: I am not certain that therapeutically induced regressions and dissociations may not lay the foundation for easier regression and dissociation at other times, and therefore do not consider them a desirable therapeutic modality.

However, I do believe in such active steps as cathartic interpretations, i.e. interpreting unconscious material directly a la John Rosen (3), without waiting until it becomes preconscious, as is more customary in the treatment of less disturbed people.

Aside from the importance of having easy access to a hospital, it is extremely desirable that it be a hospital setting in which one can continue to see

and treat one's own patient while he is there. This type of situation is often difficult to attain because teaching hospitals always insist on having only their residents and staff treat patients. In view of this fact, proprietary hospitals, which may be otherwise less desirable, are to be preferred. While the patient is hospitalized for an acute disorder, actively deluded and hallucinated, one can make crucial interventions which will speed up the therapeutic process greatly. Of course, it is also essential that the patient has a sense of not being deserted, so it is extremely beneficial when there is continuity of contact. Therefore, anyone who wants to engage frequently in the treatment of acutely disturbed psychotics has to cultivate a close relationship with a hospital that will permit him quick hospitalization and continued care of his own patient, both psychotherapeutically as well as psychopharmacologically.

Another aspect which may be even more difficult than the first two with regard to hospitalization is that it must be possible to get one's patients released from the hospital as promptly as possible. Ordinarily, administrative procedures may make it difficult to remove a patient from the hospital speedily. Yet, those patients who are suitable for ambulatory psychotherapy could especially easily be harmed by excessively long hospitalization which induces passivity and secondary gains from the hot-house conditions of support and external controls.

4) A Family Network

This point is really an elaboration of the second one, namely the requirement that there be at least one person whom the therapist car. address himself to, who will take some responsibility for the patient. If there is a whole *family network* available, this may play a crucial and beneficial role. Family network therapy has a definite and well-known place in treatment. Especially if inter-family pathology plays a marked role, it is essential to draw other family members into the therapeutic situation. This may be accomplished in different ways. Indeed, one may choose to engage in either conjoint therapy with one other family member, or in family therapy per se. Under certain circumstances,

the original therapist may wish to work with the entire family himself. In other instances, it may be more suitable to have other family members, or even the entire family, seen by another psychiatrist or social worker or psychologist. The two therapists must have the privilege of conferring with each other, so as to work as a team, even if not necessarily under the same roof.

5) An Auxiliary Therapist

The above point brings me to one of the less well-known and less practiced techniques, and that is the desirability of utilizing an *auxiliary therapist,* i.e. having two therapists treating the same patient simultaneously. The auxiliary therapist may be drawn in only during particularly stormy episodes. These may be due to an especially acute transference psychosis, or at times to a particular countertransference problem on die part of the therapist. Then the role of the auxiliary therapist is to deal specifically with the transference psychotic phenomenon which may be too difficult for the patient, and maybe for the primary therapist, to handle directly. Meanwhile, the primary therapist continues to work on the problems that produced the acute transference psychosis.

Dyadic psychotherapy, especially in an office, can be a very lonely type of endeavor, fraught with all sorts of emotions, including anxiety for both therapist and patient. Therefore, it is often very useful to have, as a routine proviso, an auxiliary therapist who can dilute the transference and countertransference, if necessary. If one routinely works with acutely disturbed psychotics, it is often useful to introduce an auxiliary therapist early in the relationship, explaining to the patient that this colleague will be available should the primary therapist catch a cold, go on vacation, or otherwise be unavailable. Such availability, of course, is crucially important with the most highly disturbed people. This kind of arrangement is made more easily in a clinic or social agency than in private practice, but it is not impossible in the latter.

6) Awareness of Family and Community Resources

Especially for psychiatrists in private practice, it is important to be aware of all possible *resources in a patient's life* (relatives, friends, etc.) *and in the community.* Social workers and psychologists are more likely to be aware of these social support systems, such as social agencies, rehabilitation facilities, halfway houses, recreational facilities, and eventually vocational rehabilitation. It is important to make use of these facilities during treatment and certainly towards the end of treatment, when the patient needs a setting in which he can continue his improvement and recovery.

7) Hot-lines and Emergency Centers

A variation on the theme of having access to an auxiliary therapist is the need to have easy access to *hot-lines and emergency centers.* Most communities, at this point, do have such services available, as part of their community facilities. These emergency services are usually listed on the inside cover of the phone book and, when they are properly administered, are accessible 24 hours a day. The telephone contact should be backed up by an available psychiatric emergency center in a clinic or social agency and, if possible, a mobile team which can visit a patient in his home and, in an extreme situation, commit and hospitalize him.

8) Do Not Be a Hero

I consider it extremely important to have *easy access to an alarm system,* in case a patient should become acutely disturbed and possibly dangerous. The ability to treat acutely disturbed people depends as much on the relative security of the setting within which therapy takes place, as on the therapist's capacity to tolerate feelings of anxiety and discomfort. Under any circumstances, *it is essential not to be inappropriately heroic.* The therapist should never allow situations to exist which are unduly dangerous in terms of his own safety. An anxious therapist can certainly not function effectively. An unsecured setting also makes the patient uneasy, because he may well fear his own possible loss of

impulse control. Especially in large and active emergency treatment centers, it is best to have security personnel available. In settings which are less likely to have extremely disturbed patients, it is advantageous to have an office which is not located in too isolated a setting. It may be helpful to leave the door slightly ajar, provided that reasonable privacy is still retained. Again, such a provision is often also of benefit to the patient, who feels less frightened of the therapist and of his own impulses, when he perceives the situation as relatively secure.

9) Housing Situations

This point deals with a very difficult problem—the *suitability of the patient's housing situation:* namely, where the patient lives and where he or she should live for optimal improvement. The family setting is often extremely unhealthy and it may be almost impossible to do constructive therapeutic work in two or three hours a week if the remainder of the time there are forces within the family setting which are regressive and pathogenic. Therefore, it is often essential, and certainly a major enabling condition, that if his present living situation is unsuitable then the patient must be moved to another setting. At first glance, this often appears to be impossible. I strongly suggest a very careful survey of all his relatives, friends and community resources, in an attempt to find a place for the patient to live and to sleep other than with his immediate family, if they are acutely pathogenic. If there are no appropriate relatives or friends, then foster homes or even half-way houses may be preferable, even though these facilities are often deleterious in their own way.

I cannot stress strongly enough the importance of proper living situation for the patient, in order not to have the therapeutic process be more difficult than is necessary, or even to be ineffective. I have found this factor, namely a healthy setting, to be so important, that if a patient of mine had a suitable family member living in another state, I was in favor of the patient moving to that other state, living with that family, and continuing with another therapist rather than myself.

10) Drugs

Finally, the use of *drugs* has to be mentioned as one very important enabling condition for engaging in psychotherapy with acutely disturbed psychotic patients. My favorite analogy of the role of medication in psychotherapy is that a drug plays the same role in facilitating the psychotherapeutic operation as an anesthetic does for a surgical intervention. It enables the doctor to engage in the often painful but necessary interventions, and still have a cooperative patient. Before general anesthetics were available, it was not only excessively traumatic, but often fatal, to perform an abdominal operation without properly relaxed musculature. A similar situation holds true for some psychotherapeutic interventions. Interpretations may be extremely painful and distressing for a patient—indeed, more than he can bear. This may provoke an episode of violence to himself or others, and lead to a more acute psychotic state. In other instances, without the benefit of psychotropic medication, the patient may be generally too anxious, too withdrawn, or too depressed to be either willing or able to communicate. Some patients may be terrified of approaching particular subject matters, material which it is crucial to air and analyze. In such instances, drugs can be used to decrease "approach anxiety" or, as in the case of antidepressants, provide the patient with the "energy" to relate.

Caution must be observed not to medicate a patient to a point where most ego functions are interfered with and reality testing and the sense of self have been unduly affected by the psychotropic drug (1). It is undesirable to have a patient who feels foggy or "spaced-out"—so lethargic as not to have any motivation for psychotherapeutic work. But it is, in fact, possible to choose one's drugs in such a way that some ego functions are improved, thereby facilitating the therapeutic process. Improvement of impulse control, e.g. of aggression, may be accomplished with lithium or phenothiazines. The latter may also improve thought processes, helping the patient to think logically and reason deductively —skills basic to his understanding therapeutic interpretations.

Summary

Before initiating therapy with acutely disturbed schizophrenics (and other psychotics), it is not only necessary to make a diagnosis in the narrow sense of the word, but also extremely important to evaluate all assets and liabilities in the patient's life situation. All difficulties which are likely to emerge in the process of treatment should be carefully assessed and planned for (2). Such accurate assessment and treatment design can serve to eliminate a great deal of trouble, waste and even tragedy.

However, if at least the minimal enabling conditions outlined above are met, the ambulatory treatment of acutely disturbed schizophrenics and other psychotics may be a truly rewarding experience for both patient and therapist. In most instances, after the acute condition has been dealt with, it is desirable to engage in extensive psychoanalytic psychotherapy in order to deal with the patient's subtle structural, dynamic and characterological problems.

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Note

1 The author is greatly indebted to Helen Siegel, M.A. for her editorial assistance.