My experience with the family and social management of schizophrenia began in 1962 at the Westchester Square Day Hospital, where as a resident I learned from Israel Zwerling and Harris Peck how to keep patients out of the hospital by working with their families. It continued for 3 years at the Adult Psychiatry Branch of the National Institute of Mental Health, where I learned that the “family” theory of the etiology and treatment of schizophrenia is a very complicated matter indeed. When I returned to the Bronx to work with Israel Zwerling, Andrew Ferber, and Marilyn Mendelsohn in the Family Studies Section of what was called Bronx State Hospital (now upgraded to Bronx Psychiatric Center), I organized and for 2 years headed the Family Service. That Service attempted, for the first time as far as I know, to base the treatment of a whole catchment area’s population of chronic and remitting schizophrenics on a family model. Further, it undertook to do so as a permanent service to that population, not just as an experiment to see what could be done with the families of a few selected cases. The experiences of the Family Service, and of its 50 or more very dedicated staff members, are recorded here under my own name. It is important to note that what we learned together, we learned the hard way; we winnowed out in the case conferences, supervisions, and planning meetings what I present here without reference to the misery and confusion involved in its discovery.

The Family Service organization has survived two changes of director and a change of the hospital director, as well as a number of internal reorganizations. It is still going strong as the treatment of last resort for the chronic patients who live in the Northeast Bronx, which has a population of 210,000. The acute psychiatric needs of this area are met by the nearby Bronx Municipal Hospital Center; we have pressed the Hospital Center to take patients with first psychotic breaks, for reasons I will go into later. Its outpatient department also sees a certain number of the chronic patients we regard as “ours.” They will in fact become “ours” the next time they decompensate; we have an understanding that if a patient presents for a second hospitalization we will handle the case if the city hospital refers it. Meanwhile, to avoid some confusing shuttling back and forth, we work to keep those patients who are already ours—about 700 on the rolls at any time—away from the emergency room and outpatient department of the Municipal Hospital. We have the same budget and line allotments as the other geographic units of the hospital, and we have to contend with the same hiring freezes and civil service regulations that afflict the rest of the New York Department of Mental Hygiene. We are special only in the enthusiasm that we generate from our own resources, of which I will say more at the end of the essay.

Before describing the Service and the population further, I want to review some matters of theory concerning schizophrenics and their families. My discussion will be interwoven with what might be termed our philosophical convictions, developed and strengthened by our experience.
The Schizophrenic and His Family

Some Points of Theory

A number of fascinating publications—mostly recent and mostly American—have tried to show that families cause, or help to cause, one of their members to be schizophrenic, and some of these have claimed to show the mechanisms by which that terrible subjugation takes place.

Frieda Fromm-Reichmann (1948) attributed it to the schizophrenogenic mother, Gregory Bateson (Bateson et al. 1956) to the family’s double-binding communication, Theodore Lidz (1973) to the narcissistic egocentricity of the parents and the schism or skew in their marriages, Lyman Wynne and Margaret Singer (1963, 1965) to the parents’ fragmented or amorphous style of communication, and so on through an impressive list of very perceptive writers in this tradition.

An etiology so elegantly worked out should lead eventually to a basis for treatment, but as Henry Massie and I showed in an earlier paper (1972), the family therapy of schizophrenia has neither been well developed in practice nor had much demonstrable success. There is almost nobody writing today who advances family therapy by itself as the treatment of choice for schizophrenia. On the other hand, an entire generation of psychotherapists, taught by the above writers, have come to understand that something must be done about the family of the schizophrenic if the therapy is to succeed.

The question is, What is to be done? The quarantine of the noxious family from the patient does not seem to work—even when the patient is in the hospital, they seem to have a way of getting back together. Performing a sort of sanitizing “therapy” on family members to turn them into a better “environment” for the patient also does not work, if for no other reason than that the family cannot stand the guilt. They are often in an agony of self-reproach over the patient’s breakdown to begin with, and to be told by the professional staff that the very manner of their love and concern is what caused it is too much. Further, that position will not form the basis of a therapeutic relationship with the family, since it implies a conspiratorial split with the good staff and the treatable patient on one side and the bad family on the other.

A Viable Model of Schizophrenia

In thinking about schizophrenia, we have had to arrive at models or descriptions with a three-way fit so that we can 1) talk to patients about it, 2) talk to families about it, and 3) talk to each other about it. Each of these three presentations must be essentially the same. It is contradictory if we say to the patient that he has “special difficulties in living” that do not have a medical name (though he knows he has a diagnosis because he is in a hospital); if we say to the family that it is true that he has schizophrenia, but it is not a hereditary condition, and there is nothing wrong with his head—it is a “functional illness”; and if we say to each other that he is acute, paranoid, and has a delusional thought disorder and auditory hallucinations. It does not solve the problem to say in a family session with everyone present that the problem lies in the family’s pattern of communication. Surely, in doing this we are subjecting the customers and each other to the same sort of mystification that—depending on one’s theory—produces, or sustains, or results from the thought disorder in the first place. The problem becomes pressing when we meet, as we often do, with large groups containing patients, family members, and staff—multiple family groups, where the focus is on understanding and coming to grips with the problem, not just in one family but in general. There we see the models in active conflict: the patients behaving as if they are being patronized or put down for some mysterious reason; the families acting as if the patients need “help” (medicine, therapy) for their sickness; and the staff talking in obscure terms about it all and then going to a separate meeting afterward where, it is understood, they talk in scientific language to each other about what they really think.

In approaching this problem of a viable model, we have taken note that the nature of schizophrenia is still much debated among the leading authorities and that all ways of talking about it are metaphors taken from medicine, psychology, art, religion, or what-have-you. Inevitably, each metaphor carries its distortions as well as its truth. We nevertheless need to talk descriptively about schizophrenia, and we try to use metaphors that are as consistent, communicative, and truthful as possible.

We begin by saying that schizophrenia is constitutional, something between a talent and a handicap.\(^5\) It is a talent in the sense that people who have it are able to notice things that others cannot, but a handicap in that they

\(^5\) I am indebted in this section to Brian Stogoll.
notice too much and are inclined to react to and worry about it all. It is in some sense physical, judging from its genetic component (Rosenthal and Kety 1968) and its physiological concomitants (Gunderson et al. 1974). To the extent that it is a disease, schizophrenia is like epilepsy, in that it is mainly manifested in alterations of behavior and consciousness. Historically it is also like epilepsy, in that it was once thought to be mysterious and threatening but is now, with the appearance of appropriate medication, coming more under control and understanding. Again like epilepsy, it requires intelligent planning with the family for its management more than it does medical treatment. What we want to avoid are the illness connotations of the disease model—the social role of a sick person incapacitated until properly treated. We want instead a disease model that implies retraining and rehabilitation and the avoidance of situations that lead to recurrence. This can be more potential than actual, as in epilepsy or well-managed diabetes. And like diabetes, it is a syndrome with an outcome that can be affected by many factors and can take different final forms. The analogy with diabetes is useful in talking to patients and their families because they can usually perceive from their own experience the parallels that:

- Schizophrenia gets worse as a result of stress;
- You can live with it and hardly know you have it;
- Some forms of it are managed by long-term and relatively benign medication;
- It manifests itself in different ways at different times of life; and
- Its heredity is not a simple matter.

It may come as a surprise that a family approach to schizophrenia can embrace a disease model, considering how long such family theorists as Laing and Esterson (1971) and Murray Bowen (1960) have labored to take the diagnosis and the labeling, or in their words the scapegoating of the patient, out of the process of treatment. Laing and others have been careful to call it “madness,” a kind of derangement common among us all from time to time, connoting outrage common among us all from time to time, connoting outrage and protest and perhaps a deeper sanity than the insensitive normality of the average person.

I have several reasons for talking in terms of a disease that appears in certain constitutionally disposed people when the conditions are right: 1) It is close to the way in which the culture has come to think of such people—they are “crazy,” which is a way of being “sick,” and that is how many of the patients, as members of the culture, think of themselves. 2) There is a great deal of medical experience and research—the use of medication, for instance—which suggests that concept; this medical model would be almost impossible to deny or discontinue, but it can be moderated in some important ways. 3) The medical model of a constitutional predisposition is not so pejorative today as it was in Kraepelin’s time; we no longer speak of “degenerate stock” as he did, but rather of tendencies, such as a constitutional predisposition to collagen disease, diabetes, allergy, or hypoglycemia, or of inborn errors of metabolism and differences of temperament. 4) If the family therapist can relax about calling schizophrenia a disease, he is better able to talk in social-process terms with the patient and family; he will have their respect, since they will not see him as defending a dubious position, and they will be better able to model their attitude after his.

What are the characteristics of this disease? It appears under stress. It is a special way of responding to change. Everyone’s life contains occasions of stressful change in which the customary supports for our sense of who we are become especially uncertain—or unavailable. Adolescence, moving, going to a new school, courtship, marriage, childbirth, job change, death or the threatened loss of a family member—any of these experiences can make any of us lose heart, become depressed, be uncertain of what to do next, and appear distracted or preoccupied to our fellows. They require movement into a new life with a new group or an altered sense of who one is in the old one. Sometimes it is not a definite environmental event or a real change of role. The most devastating change can be the loss of an illusion—the realization, for example, that one is no longer young, or respected, or that a loyalty or promise on which one was secretly counting will never be made good.

Our culture has endorsed several ways of responding to these crises of self-confidence. One healthy reaction that middle class people have learned, for example, is to see the change as a challenge to personal growth and career, to seek the company and support of others who have been through it, and to consult experts for technical advice. Other cultures arrange rites of passage in which the role change is ceremonially recognized. In some of these the person going through the upheaval is ritually encouraged to withdraw into a special nonfunctional status for a while. He is allowed to “retreat.” So American adoles-
cents “drop out,” and since that withdrawal has a name, social status, and probable duration, it is tolerated by parts of the society.

Some people cannot respond to these crises, experiencing them as a rejection of themselves by a new group or by the old group as newly reorganized. They sense this rejection as a personal failure of a very radical nature, what Sullivan called a “rebuff,” from which they do not recover. Sullivan (1962) said:

We find that the stricken individual, following the peculiar and characterizable failure to react to rebuff, has lost a great part of the confidence in the integrity of the universe, the goodness of God, and so on, which is our common human heritage from infancy; and that from thence onward he goes on feeling decidedly uncertain about life. Apparently, if one is sufficiently uncertain about life, one loses the cognitive assets which serve us in distinguishing products of autistic or purely subjective reverie from products which include important factors residing in so-called external reality; and when one has lost this ability to distinguish between such reveries and such objects having more external points of reference, one begins to sink into mental processes significantly like those that we experience when we are asleep.

With the appearance of a partition in which considerable waking time is spent in a condition in which one is without the ability to tell what has true, genuine, and consensually acceptable, external references, and what instead is purely personal fantasy, there appears a peculiar disorder of social activity (and I might say even of nonsocial activity), and it is these peculiarities that seem to constitute the essence of schizophrenic behavior. [p. 221]

In having difficulty responding to rebuff, schizophrenics are clearly like the rest of us—they are “more simply-human than otherwise,” as Sullivan said. But they do have a great difficulty in responding, some part of which is a constitutional intolerance for change of this kind. They tend to respond awkwardly to strangers and new situations, to fail to learn or to misapply the social forms that the group provides for handling, in Sullivan’s terms, the “integration” of new situations. And so their symbolization of the nature of the change—their thinking about what is going on—will be different from that of the primary group that might help them through the trouble. They withdraw, their thinking becomes private and specialized, and they fail to communicate or understand. The emotional and gestural signals by which they indicate their place in the social process—for instance, the eye movements and the timing of speech—all are “off” (Scheflen 1973) and are seen as “alien” by others.

A crucial event then takes place within the group (the family, school, clan, or village). The group decides that the person who was hitherto one of them, in that they all shared a common set of meanings about what was happening, is now not one of them, is alien, and is crazy. This means that the person cannot be dealt with by “reason”—that is, by the usual social forms of control—but must submit to some special process of control and reintegration into the group, which in our society is called psychiatric treatment.

We can now look back at the writings on the family etiology of schizophrenia and see that they were describing the social process of the family group as it “drives the person crazy” (Searles 1965), and that it would be a mistake for us to locate the impetus for this in either the family or the patient—it is an interaction in which both participate. And we can now also describe the social setting in which schizophrenia takes place in a way that will lead to a rational treatment program.

The Social Setting of The Schizophrenic and His Family

This social setting can be looked at as a series of concentric rings surrounding the patient in which the innermost one is the family.

The Family

Certainly what has been said about the family of the schizophrenic has been borne out by our experience: The secrets (Paul 1970), the unresolved narcissistic dependencies, the covert communications, the double binds, the projections, and the whole nightmare of repetitive cycles within the cohesive isolated group (Henry 1971) are all to be found. But these observations do not necessarily lead to a plan for change. It is not enough to uncover secrets or to straighten out communications. The attitude of the family members toward their predicament must be changed by offering them an alternative structure for it—by giving them a positive way of dealing with it in the form of new opportunities and new people with whom to interact.

The family members have failed to see the psychosis as a developmental crisis and have instead projected their
doubts and ambivalences onto the patient. They see him as having a “screw loose” that some doctor or hospital has got to tighten, or they see him as in need of special efforts on the part of the family caretaker—usually the mother—to encourage him to greater willpower and determination. The family members have to be encouraged to see the psychosis of one of them as part of a process of change that they are all going through: Each one responding differently—one with psychosis, others with headache, insomnia, flight, unemployment, or exhaustion. The end result will be that they all must live in some new relationship—the next plateau in their lives, where the caretaking of everyone will be different.

The Network

The schizophrenic and his family usually lack a network of connections with society. In order to establish such a network, it is usually necessary to experiment with new relations between the family and others—the extended family, the professional “family” of the treatment team, and other families in the same trouble. Typically, the families of schizophrenics are isolated from their environment in a number of ways (Speck 1973); they are often ashamed of having a chronic patient living in the house, or their relatives and neighbors find them difficult and unrewarding. The family members close themselves off and restrict their lives, so that the futility and repetitiveness of their behavior and thinking feeds on itself.

Work and Public Life

Schizophrenics are often further immured in their families or in their private rooms by the judgment of the outside world that they are not congenial or productive workers. In a society in which much of one’s sense of self comes from being either publicly congenial or productive or both, this is a large setback. Getting and keeping a good job is often the worst kind of terror for schizophrenic people, since it involves meeting strangers, making an impression and dealing with the coldness, ambiguity, and bureaucracy of the society’s larger structures.

Bureaucracy

Once schizophrenics have been classified as unproductive, and thus at one with the poor, the crippled, the criminal, and the children, then the largest units in the society, the great superagencies of government, bring to bear on them the merciless subjugation that is called “social service,” “psychiatric treatment,” or “welfare.” For anyone who is frightened by ambiguity, uncertainty, and mixed messages, this is the ultimate experience of a rejecting parent who cannot be labeled as such. Protecting patients and their families from the bureaucracies that are set up to care for and control them is the hardest part of our job on the Family Service.

Looking at these concentric social rings around the schizophrenic, we can see that we are not dealing just with a disordered “thought process” or even with a disordered family communication system. These are only the most centrally identifiable parts of a career, a life in social context. In a moment, when I come to the case histories, I will show that there are indeed several possible careers, and probably as many “schizophrenias.” But still speaking of them as one, we can say in general that the job of treating this disease requires the marshaling of an organization that will address itself to the whole life of the person and not just to a part of it.

It is no accident that for so many centuries our production-conscious society locked schizophrenics up in asylums—it was an expression of the fact that the life and career of the patient as a whole was an affront to the society, and vice versa. It was for this reason that in mercantile 17th-century France they were first herded, together with the poor and the criminals, into the empty leprosaria (Foucault 1965).

Now that ever larger numbers of patients are living outside the asylums in a society that is often still unwilling to tolerate them, and knows well how to drive them back into the crazy house if they get out of line, the job of the treating organization becomes twofold:

- Teaching both patients and their families and others to tolerate each other in all their idiosyncrasies—making life possible in whatever odd places the patient’s career can fit in with the careers of others; sometimes creating new places for people to live and work.

- Anticipating and preventing or smoothing over the crises of confidence, the changes that produce acute psychotic episodes in families where things were previously stabilized. This has been called “crisis intervention,” and it is a large part of our work.
Those tasks dictate the design of the treating organization. It is further dictated by some features of the natural history of schizophrenia as we understand it.

- The patient is the person in the social system least able to bear the strain and responsibility for making changes. In fact, as we said, our definition of schizophrenia is that it is a constitutional intolerance for certain kinds of change, and therefore it requires more tolerance from others.

- A primary condition for a schizophrenic's stabilization is clarity concerning what is happening in his intimate social world. The encounter between that world and the therapeutic team, along with everyone's comments about it, is presumed to promote that clarity. The idea is to create clear opportunities for change—openings in the thicket—without leaning too hard on the patient.

- A tolerant environment peculiarly suited to the patient's life and development may look very strange to others; it should involve as few dogmatic assumptions as possible and no bureaucratic formulas—just lots of opportunity.

- The family and patient sense that their predicament may last a lifetime. They are not helped by a plan to fix them up and then leave them on their own, because they know there will be more trouble.

From the above needs of schizophrenics and their families, we arrived at the initial design of our family service:

- It had to be small enough to be unbureaucratic. The Service is staffed by about 50 people, and the work groups are not larger than 10.

- It had to be large enough to do everything for its population, while providing continuity of care. We set up three crisis intervention teams, a day center, an inpatient ward with three shifts, and a foster care unit. We started therapy groups, multiple family groups, activity groups, and drop-in medication clinics.

- It would be generally nepotistic in that there were social friendships and personal trust among many of the founding members. No one was accepted because of trade union or civil service credentials such as seniority or having passed examinations. From the start we had the benign patronage and protection of the director of the hospital and the top business officer, without whom we would not have had the almost complete administrative freedom that the enterprise needed.

- We would be flexible and unhierarchical, so that novel solutions to peculiar problems could be undertaken without straining anyone's dignity, job description, or place in the organizational chart.

- As part of a permanent care delivery system in the State Department of Mental Hygiene, which is set up to give care forever to this population, rich or poor, we could, in sincerity, make a lifetime contract with our patients; we would not have to turn them away for lack of funds or insurance.

- Thus we would be able to provide in the atmosphere of the Service, from its general design to the individual attitudes of its people, the note of hope that in my reading of studies of the treatment of schizophrenia, appears to be the indispensable—and sometimes the only effective—ingredient.

The family and social system approach permits us to focus on the world around the patient, rather than grappling with him alone in his isolation and despair and ambivalence. As we cheerfully work away at the configurations of people who surround the patient in his life in the family and on the ward, the patient often gets better while nobody is looking at him so intently. This, more than anything else, is the theory behind the treatment approach of the service.

This treatment approach is as much oriented to the morale of the family and of the treatment team as to the condition of the patient.

In the next section I want to summarize our experience with three different types of patients: the first-break, the periodic, and the chronic, and to explain briefly what we have learned about the differences between them. The section includes stories that illustrate both these different clinical courses and the key elements of the Service in operation.
Types of Schizophrenia

Kraepelin originally introduced the idea, still in use, that the way to classify schizophrenics is by their course. He thought that symptoms and other discrete phenomena were important, which we have come to doubt. But we distinguish different types of social career, a sort of interaction of temperament and opportunity that produces several different kinds of lives. This is close to the original "psychobiology" concept of Adolph Meyer (1973). We can best develop the concept of the patient's course or career in the context of the different types of patients.

First Breaks

People who are becoming psychotic for the first time in a rather definite and dramatic way, especially if they are young and have had "good premorbid" lives of fair social adjustment beforehand, have attracted special interest ever since Sullivan (1962) pointed out that they sometimes have a good prognosis. He noted that this is especially true if the catastrophe is reshaped as an opportunity, a crisis in development, and if the family is somehow kept at bay. His special ward at The Sheppard and Enoch Pratt Hospital in Towson, Md., was designed to treat the break as a human phenomenon leading to a reorganization of the personality, perhaps a useful one. Loren Mosher (1972) has advanced these ideas in the design of his Soteria House, an experimental treatment facility in the San Francisco Bay area where young and accepting staff members who have this view of psychosis work with the patient. A number of reports (see Guttman 1973) and our own experience indicate that if the patient is an adolescent, intensive conjoint family therapy is contraindicated in most cases.

If the patient is older and is having a psychotic reaction to adult life—such as a reaction to divorce, a postpartum psychosis, or a midlife or involutional crisis—the phenomenology may be similar, but the indications for family therapy are positive, as I will show later in the story of Edna. The point I want to make is that the first psychotic episode requires special handling; there is evidence that if this is provided, the break need not be repeated. Moreover it can change the patient's career in a decisively positive sense (Bowers 1974). Such successful outcome depends positively influencing the attitude of the family and patient toward the crisis' meaning for the future.

Periodic Patients

If there is a second break, we may be heading for a different kind of experience and a different career. Patients with the definite and dramatic onset of schizophrenia described above may reach a social adjustment and then go through the experience of psychosis all over again. When this becomes a pattern, we note that these patients are still different from other repeating patients, the chronic ones. Periodic patients are more out of the hospital than in—that is the most objective definition of their careers. They may also be better able than chronic patients to work, to live with their families, or to live alone, as many of them do. They have an interest in becoming more skilled in both public and private life and a cautious interest in learning to recognize and cope with change. They and their families are interested in forestalling the next crisis or the one after that, and they sometimes succeed.

Chronic Patients

These patients are more in the hospital than out. Many of them had the kind of slow, early, and insidious onset which is described for process schizophrenia. Many had a poor premorbid history. Some have organic difficulties as well. They are less likely to be married, generally have a poor work history, and their families, when they are on the scene, find living with them less manageable than do families of periodic patients. All these things no doubt feed into one another, but we see no evidence that the more chronically hospitalized the patient, the more rejecting the family; we think we can distinguish between these chronic patients and another group of patients whose careers were like those of periodic patients up to a certain point in their lives. At that point, however, their families decided they were through with them, and the patients got into a power struggle to influence the families to take them back. The result is a standoff, with the patient making his combat headquarters in the hospital. These patients are in the hospital for years, not because of their own requirements but because of a shift in the family’s expectations.

In the next section I will present some stories in the form of case histories and anecdotes. The stories are designed to illustrate the types of career I have referred to above and to show the handling of these problems by different parts of the Service.
These are not real cases—they are fictional combinations of aspects of cases that seem to me to fit together, assembled to make some of the points I want to present. They should therefore not be read as the usual case conference or report, or as scientific accounts of what worked and what did not. It is difficult to talk about effectiveness in the treatment of schizophrenia—the criteria of success rarely have to do with cure or change, but more with stabilization and placement. We cut the number of beds used by our catchment area in half, and likewise halved the admission rate, in our first 2 years of operation. But the question remains—what should we expect to be able to do for these people?

Careers in Schizophrenia—Some Stories

Ralph Melzer

When we first saw him, Ralph was 17, a slender, intellectual high school senior who apparently had always been rather anxious and retiring. In the special New York school where he majored in physics, however, he had recently experienced an increase in self-confidence as a result of joining a group of Marxist student activists. He had an older sister, Miriam, 20, an English major at a city college. His mother was a school guidance counselor and his father worked long hours as the owner of a small manufacturing concern in the Bronx.

Mr. and Mrs. Melzer were both communists when they met in their youth, but Mr. Melzer was now disillusioned with the prospects of the revolution. He and Ralph had been speaking even less since Ralph became a Marxist—their occasional conversations resulted in angry political shouting matches from which Ralph would finally retreat. Miriam and Mrs. Melzer, though more in agreement with Ralph, felt torn between the two men. Ralph would have long, unsatisfactory talks with his mother and sister about politics, and avoided talking about his personal life. On rare occasions he revealed to Miriam a largely fantasied relationship with a girl in his student group.

One day after the group had finished a sit-in lasting several days, Ralph disappeared for a week. He showed up disheveled, mute, and terrified, at Miriam’s college. She got him home with much difficulty. When he saw his father, he became rigid with fear.

With the help of neighbors the family brought him to the municipal hospital emergency room, where they were regretfully told there were no beds, and so he was committed to the State hospital. He arrived on the ward of the Family Service in the middle of the night, stuporous and dehydrated. He was given Thorazine, and the next day the inpatient staff began to coax him to eat and drink and talk a little. The crisis team then met with the family, including Ralph himself.

The crisis team consisted of Mildred, a psychiatrist, Ellen, a social worker, and Mike, who was an assistant therapy aide (ATA). This group was selected to work with the case mainly because Ellen, the social worker, was on call that day; Mildred, the psychiatrist, was needed for evaluation of the new case; and Mike, the ATA, was a man that Ellen liked to work with. Ellen knew she would probably be managing this case; she had a hunch she would need a man to help the team relate to this catatonic young male patient.

The family meeting lasted 2 hours. Ralph kept running in and out, and Mike walked with him and reassured him as he paced the halls. Mildred and Ellen, having gotten the story, tried to get Ralph and his father to talk to each other, but Ralph ran out of the room again. The meeting ended with a plan to contact the leader of the student group and to meet again with the family, perhaps without Ralph.

Ralph was quite upset after the meeting and paced the floor that evening with Art, an ATA on the evening shift. He told Art he was sure his father wanted to kill him or at least castrate him because he was a homosexual. Art told him that was a very common fear among people going through a psychosis for the first time. Ralph also talked with Art about his fear of the other patients in the hospital.

That evening Ralph was visited by some members of his student group and talked a long time with them. He seemed much calmer after the conversation and went to bed. The next afternoon, though he was under escape precautions (meaning he was in pajamas), Ralph disappeared from the ward. A day later his mother called Mildred and told her she had heard from the leader of the student group that Ralph was with them. He was about the same, still fearful, but eating and drinking and talking with them. The group had some ideas, from reading Ronald Laing and seeing “Wednesday’s Child,” about how such situations should be managed. They didn’t want to bring Ralph home or to the hospital, but wanted to assure the family that he was all right.
The crisis team of Mildred, Ellen, and Mike, plus Art and the head nurse of the inpatient service, arranged to meet with two members of the student group and the family to decide what to do. The meeting lasted 3 hours, during which many things happened. There was an exchange between the student group’s leader and Mr. Melzer that revealed, in a way that Mr. Melzer could hear, that Ralph wanted to get in touch with his father but could not. Mildred, by sympathetic questioning of the students, brought out their ambivalence about managing Ralph. Opinions about the danger of suicide or further decompensation were discussed. The students said that Ralph really wanted to stay with them, and that they would consult with Mildred if they needed advice. Mr. Melzer argued for going after him with the police. Mildred, after much hesitation, decided to send Ralph a letter about the meeting, signed by everyone present. It urged him to call Mike or Art if he got into something he couldn’t handle, but endorsed his staying with the group for a while if he thought that would help. The letter explained that the team would go on meeting with the rest of the family. Mildred persuaded the group members to take some Thorazine with them for Ralph, and they agreed to give it to him in spite of their prejudices against it. It was agreed that Mildred would be consultant to the group.

During the next weeks Ellen met with the three family members a few times and, by getting Miriam to talk to her father about Ralph, prepared them for the idea that Ralph, if he returned to the family, might be quite a changed person. The meetings dealt with the father’s identification with Ralph, and with his disappointment and sense of loss.

Meanwhile the student group was getting tired of looking after Ralph. They were taking turns staying home from school, but sometimes he was alone at the apartment of the older brother of one of the group, where he slept. Mildred and the student leader agreed it was time to meet with Ralph again and make new plans. Ralph agreed to meet with Miriam and the team, but not with his parents.

When he “surfaced,” Ralph was bearded, strangely dressed and had lost some weight. But he was articulate in a very slow and cautious way. He had decided he was not a homosexual after a conversation with the girl of his prebreak fantasies. He had also decided his father was not out to kill him, but still did not want to talk with him. He had begun work on a written explanation of what had happened to him, viewed in terms of Marxism and astrology.

In the course of the meeting, Ellen began to work on plans for the future. The next weeks were busy for Ralph—they included a return home, a readmission, a final settling into a halfway house, sporadic attendance at the day center, and the beginning of individual therapy with a psychologist interested in working with this kind of problem. None of these arrangements went smoothly, but after much difficulty a program was patched together. Thereafter Ralph had a very rocky course, but he was not rehospitalized. The parents continued to see Ellen to discuss their adjustment to their son’s strange new way of life and his alienation from them.

Here, with the case unresolved but with the elements of treatment in place, I will stop and present some of the points this story raises:

1. Ralph’s case should never have come to us, but there is no good place in the Bronx for his kind of problem. The area does not have a really sequestered, receptive place like Soteria House. In retrospect, the student group functioned as such an environment for him, accepting him in his changing identity.

2. The team managed the crisis of Ralph’s escape by calling a meeting of his network and working out plans with everyone present. They did this rather than reacting to Ralph’s “absence against medical advice” by trying to recapture him, which would have been the correct response under hospital policy.

The emphasis in the meeting was on having everyone present, on getting ideas from everyone, and on coming to a conclusion, all of which maximized and clarified the communication. The letter to Ralph, telling him everything about the meeting and letting him know who was in charge and who was going to be meeting with whom, was very important. It was the best way to guard against escape and panic. It also validated Ralph’s only positive communication, which was that he wanted to stay with the student group. It was a move that dealt with the immediate problem of what to do but that also left the door open for a number of later developments. It thus followed Jane Ferber’s rule of crisis management: “Think about what has to be done next.”

Most of the adjustment was expected from the parents and the leader of the student group, so they received strong support in coping with new developments through meetings with Ellen and Mildred. Miriam (the well sibling) and the student group leader were used as spokesmen for
Ralph in the family system, since the father could not face him directly.

Family therapy of an intensive type is not indicated in this kind of situation because the emotional responses of fear, disappointment, and despair are so strong that the family group can only with difficulty see the first schizophrenic break as an opportunity. The adolescent patient is in the midst of a transition with little group support, either from the past or from the society that is to be his future. He has to develop some of his new personality with the help of other, non-family therapy; some time must pass before this happens and a meeting with the family is possible. Until then, work with the parents is useful for preparing them for the change.

For contrast, I will tell the story of a first break we handled well with family therapy.

Edna Hogan

Edna Hogan, 24, a stenographer, is the youngest child of a "professional" family with three other children—Jane, a nurse; Mary, a teacher; and John, who is a lawyer like his father. Everyone in the family is married and successful except Edna.

When she came to us, Edna was the only one still at home with her parents. For 2 years after graduating from college, she had a job in a law firm as secretary to one of her father's law school classmates. She was quiet and respectful, and had made one friend in that office, another secretary.

Within the same month, both this office friend and Edna's next-oldest sister, Jane, were married, and Edna was a member of both weddings. Afterward she became somewhat depressed with a flu-like illness that kept her home from work. During the next 6 months she had a number of medical consultations, since she seemed to be very weak and could scarcely get out of bed. A neurological workup was negative. To one of her doctors, she confided that she thought her employer had a secret means of having intercourse with her as she lay in bed at home. She had never told anyone about this because it seemed very crazy to her; she begged the doctor not to reveal it to her family, but she did think it was the cause of her illness. She told a psychiatrist who saw her next that she now was not sure whether the person with whom she had the mysterious sexual contact was her employer or a rock star she had seen on television. The psychiatrist recommended hospitalization. At the hospital, Edna convinced the admitting resident that the whole thing was a mistake and that she would seek psychiatric help. She went home and went back to bed.

A neighbor put the family in touch with our Service. Two members of a crisis team, George, a psychologist, and Sue, a social work student, arranged with the parents to make a home visit. Edna would not speak with them on the phone, but she did get out of bed when they arrived and joined in the meeting.

The team made three visits over the next 2 weeks. Edna sat through these rather silently while George and Sue talked to the parents and whoever of the sisters and brother were able to join them. The family wanted the team to provide treatment for Edna, but George told Edna that he thought she was being silent because she had no reason to trust anyone yet, and it was all right with him if she listened in until she felt more comfortable. The team also made it clear that they were meeting with the family not because they thought the family was the cause of Edna's trouble, but because they knew from experience that the family might be the people who could help figure it out.

At the first meeting George and Sue, after some social pleasantries, began by making a genogram, a diagram of the family (see figure 1). This is a standard procedure in our first meetings, and is important for 1) understanding what is happening; 2) focusing attention on the family rather than on the patient; and 3) arriving at a contract and plan. George put a large sheet of paper on the table where everyone could see it, took a marking pen, and asked for the family's help in making the diagram, which took about half an hour to complete.

During the course of this work, George and Sue noted the following:

1. Mr. Hogan (James) had had a bad year in 1950, when both his parents had died. That was also the year before Edna was born. Mr. Hogan said the funerals were almost the last time he had seen his brother and sister in Boston. There was considerable coolness among them, which had partly to do with arguments about the parents' wills. Mr. Hogan vigorously denied grief or resentment.

2. Both Mr. and Mrs. Hogan are youngest children. Mrs. Hogan (Theresa) said she was once very close to her sister Angela in Buffalo, but had not seen her in many years,
Figure 1. Genogram of the Hogan family.
though Angela had offered several invitations. Angela looked after their mother, Marie.

3. Edna looked blank as her father detailed the professional accomplishments of the other children. When her mother said she had not seen her sister in 10 years, Edna reminded her that it was only 8 years since she had gone there. When Mrs. Hogan said her brother-in-law was a business man, Edna half-smiled and said "junk dealer." Her mother shared the smile. George and Sue noted the covert alliance between Edna and her mother and felt that though Edna said almost nothing else during the interview, she was not so acutely psychotic that she could not observe and make effective disagreement. A family's and a patient's best level of psychological functioning comes to the fore during a concrete task, like the genogram. They are grateful not to be attacked first on the salient aspects of their pathology.

4. There was an angry exchange between Jane and her father when they were talking about Jane's children. Following this, an exchange of glances between Jane and her mother led to an inquiry into how Mr. Hogan and his other children got along. The tension in the room mounted rapidly, and Mr. Hogan launched into a disconnected tirade against Jane and Mary. At several points he got their husbands' names confused.

5. As the interview went on, George and Sue referred frequently to the diagram for new areas to explore, and generally indicated that "the problem" was not Edna but was "in there somewhere."

6. At the end of the meeting, the diagram was used again to make a contract as to who would be willing to attend meetings and at each meeting the minimum membership the team would accept.

What emerged in the meetings did indeed clarify the problem. Mary, John, and Jane had each kept a very fixed distance from the family since their marriages, returning only to participate in stormy arguments with their father, who tried to interfere in many details of their lives. Their mother was paralyzed by these scenes, had been depressed since Jane's marriage, and had started to drink in secret. Everyone in the family had been worried about their mother; each confessed to the guilty thought that maybe Edna would remain to keep her company. The guilt was related to a "worry" about whether Edna would ever marry. No one had seen any of these problems as reflecting a difficulty in Mr. and Mrs. Hogan's relationship—that was strongly denied by all when Sue inquired about it.

After this, the team moved the meetings from the home to the Family Service office. In time they got some of the fights between Edna's siblings and their father clarified, and encouraged Edna to comment on discussions in which she had an interest. Edna took a turn for the worse after the group talked about the parents' marital difficulties, but improved when the team urged her to realize that she was not responsible for her parents' happiness. The team asked her to spend a weekend with Jane and her husband to see what would happen if her parents were left alone, which she did. The following week Edna startled everyone by saying she was going to get a job in a place that had a typing pool. She had not liked the old job; she confirmed Sue's speculation that she had thought her former employer was a spy for her father. She agreed that it would be hard to go for a job interview feeling as shy as she did, so she had some private sessions with Sue at which she talked about, and practiced applying for, a job.

Edna's successful application for a job was accompanied by great tension in the family, a new round of discussions about whether she would ever get married, and detailed inquiries as to whether she would be bored or exploited. George and Sue amplified Edna's mumbled statements that she liked to be with other typists and didn't like the high-powered professional atmosphere the rest of the family claimed to enjoy. The team worked on the family's disappointment in Edna as being "different" from the rest of the family. During one of these discussions her mother cried and said that she had felt Edna was the only one in the family who understood her. This led to tears all around and more discussion of Mrs. Hogan's limited life, her drinking, and her need to talk to more people. Two weeks later, at the team's urging, Mrs. Hogan made her first visit in 8 years to her favorite sister in Buffalo. While she was away, Mr. Hogan got drunk and assaulted Jane's husband, after which a new atmosphere of candor appeared in the family sessions. Edna kept her job, and the other family members continued to talk about and accept their differences from one another, with Mr. Hogan protesting and filibustering all the way.

There are several points to be made about this successful case.

It was not easy. There were endless telephone
negotiations throughout and many cancelled appointments. Edna's silences were maddening. Many times she diverted meetings by wanting to go back to bed or by refusing to come at all. Mr. Hogan was a skillful opponent, and he and the team had wearying power struggles as to who would run the meetings.

There are some important differences between Edna and Ralph as patients. She was older and had some good experiences with work and friends in her past. She was able to use "getting sick" to put herself in the way of help and had some insight that her problems might be psychological. But beyond this, there was the general sense that Edna's psychosis was not such a radical upheaval in the life of either the family or the individual as was Ralph's. In Edna's case, there was a large supporting network to work with.

Some of the factors that I think contribute to success are present in both cases: Both involved upper middle class, professional families that shared values with the team members, such as the power of communication and understanding in human affairs. Both families had some intellectual tolerance for individual differences, meaning that the teams could better work with their emotional dread of those differences that they saw as deviant. Both families had the financial reserves to take time off from work and to avoid, in general, the kind of panic, rage, or hopeless resignation that hits a lower class family when a crisis occurs and their small margin of resources has to be spent in adjusting to it.

Edna's family, once it settled down, required the attention of two team members about 1½ to 2 hours a week, including consultation and telephoning. This is unusually economical. The cases I will present in the rest of the paper required greater outlays of people and time, especially at the beginning. But the point I want to make is that George and Sue could not have undertaken the case without the backing of a large organization that could help if Edna had to be hospitalized. Small outpatient agencies regularly fail with cases like Edna's because the workers lose their nerve when the going gets rough, fearing they will lose the case to a hospital with which they have no connection.

A Periodic Case

Mae Franklin

Mae was 38 when she came to our Service as a hospital admission in the middle of the night. She was brought in screaming and battling two policemen, accompanied by her husband Arthur, who was very businesslike and aloof and who indicated to the staff that he had been through this a number of times before.

Mae's first hospital admission had been after graduating from high school in Jamaica, and her second followed the birth of her first child Ernest, now 16. Arthur said that during that episode he first learned from Mae's mother that she had been "sick" before, and that he felt he had been sold damaged goods. Neither Arthur nor Mae's mother was surprised, then, when Mae had to go to the hospital again after the birth of a second child, Annette, now 12, and after that, Arthur resigned himself to having a sick wife. He was also from Jamaica, and had no immediate family in the area. He drove a taxi which he had bought with his own savings and some money from Mae's mother. Thus he could arrange his hours to help care for the children. A natural alliance had developed between him and Mae's mother as Mae's two caretakers when she was "going off."

This she did every 2 or 3 years. She would begin with a flattening of her already rather restricted, polite range of affect; she would become very quiet and spend time staring at the wall. She would then announce a discovery—usually that a neighbor had told her Arthur was being unfaithful—and would then start to pester her mother, Arthur, the children, her married sisters, and finally the minister and the police for more information about her discovery. She would get angrier and more excited and demanding, and finally, after some sleepless nights, she would be brought to the hospital in the state in which we first saw her. She usually got better quickly on medication and left the hospital within 2 months.

She was in fact quiet, but still very guarded and suspicious, at the family meeting that was held on the 2nd day of her admission to our ward. Those present at the meeting were Arthur, the son Ernest, Mae's mother, and one of the sisters, and for the Service, Hal, a psychiatrist, and Arlene, a nurse on the ward who was also from Jamaica. The history was given in a very authoritative tone by Arthur and Mae's mother, speaking in turn. Efforts to get Mae to tell her story were met with sullen mutterings from her, at which her mother and sister would cluck their tongues reprovingly. In a side conversation with Arlene, however, Mae did say that it always made her mad when the family threw her in the hospital. What was happening was not her fault, since she was the victim of witchcraft. Arlene said she knew something
about witchcraft and asked if someone had put a spell on her. Mae confirmed that she had heard voices telling her through the television set that Arthur had a woman who was putting a spell on her to make the family hate her.

Hal and Arlene concluded from the meeting that the family had acquired a stereotyped way of responding to Mae's psychotic episodes, and that whereas she would probably again recover rapidly, it would help in the future if this break could be handled differently. At a second meeting with the same group, Hal and Arlene suggested that Mae be transferred to the day center. Hazel, a nurse who worked at the day center, was also present to talk with the family about the transfer.

Mae liked the idea of going to the day center, since she could be home evenings and weekends. She was worried about what was happening to her family and about the time Arthur was taking off from work. Arthur and her mother “reassured” her that the family was getting along just fine, and Arthur said ominously that he certainly didn’t want Mae leaving the hospital until she was quite well and free of delusions.

Hazel explained that the same treatment and activities, would be available to Mae in the day center as on the ward, with the added advantage that she would recover more rapidly because she would have more of a chance to practice responsible behavior again. After considerable dubious discussion with the family, a contract was worked out: The new treatment team would be Hazel, the nurse from the day center, and Ann, a dance therapist there. Mae, Arthur, and Mae’s mother would meet weekly for a while with them. Mae would start doing whatever household work she could at home nights and weekends and would come to the day center weekdays. A few days after she transferred to the day center Mae chose the telephone switchboard as her job, and on the advice of Hazel, joined a women’s group in addition to her regular group of 10-or-so patients who met with Hazel 3 mornings a week. This schedule of activity was drawn up in a written contract and signed by all parties, to run for 2 months and then be renegotiated.

Mae found the day center a friendly and businesslike place. It reminded her of a garment loft she had worked in the year before Ernest was born. She got involved in sorting and mending the clothes the center was collecting for its thrift shop. Her first weekend at home was quite tense, since it was clear to her that Arthur did not want her there. He and the children seemed to be walking on eggs, treating her with exaggerated consideration. Mae concluded that Arthur did not want her around because he wanted to be with the woman who had cast the spell. She decided to stay at home on Monday morning to see if she could force him into a revealing move. There was a shouting match in which Mae refused to go to the center and also refused to let Arthur leave the house. Arthur called the center to say that Mae was getting sick again and that he thought she should be in a full time hospital.

Hazel and Ann asked Hal, the psychiatrist, to join them in an extra meeting with Arthur and Mae that afternoon, agreed to after a long telephone exchange between Hazel and the couple. It was a stormy meeting, but Mae did not become assaultive and, as Hal pointed out, did not base her suspicions on hallucinations or delusions, but directly on her interpretation of Arthur’s behavior. Hal gave a very professional talk to Arthur about the connection between his distant behavior and Mae’s suspicions of infidelity. He said he understood that Arthur couldn’t be aware of this, but that it was going to be an important thing to work on. Mae appeared relieved, and agreed to come to the center regardless of her suspicions. Hazel and Ann renewed their contract with the couple to work on the problems they were having with each other. Mae said it would be better to meet without her mother, and that was agreed to. At the end of the meeting Hazel and Sue emphasized that it was behavior they were interested in, not the craziness or sanity of anyone’s ideas. They asked Arthur and Mae to think during the week about what each of them did that the other didn’t like, and bring a list to the next meeting.

This training in focusing their anger continued in meetings with the couple for the next several weeks. In her women’s group, Mae met two other black women with stormy marriages. In talking with them she realized that she had very little experience outside her family. She had been preoccupied with rearing her children, a task to which she had never felt adequate, and had accepted her mother’s and Arthur’s supervision and criticism. She had fewer friends than her sisters and, even when her children were independent, had a strange hesitation about getting a job. Hazel suggested to her, in a one-to-one talk, that she had had a very narrow life, in which “getting sick” had been the only breaking-out.

The following weekend there was an angry shouting match between Arthur and Mae and her mother. Mae appeared on Monday morning sullen and withdrawn, and only after much coaxing from Hazel told the morning group about the fight. She had no idea what started it, but it had been about all the old topics. Hazel and Ann
decided to ask Mae’s mother and the oldest sister to the next family meeting.

That meeting lasted 2 hours. With the help of the sister, the team defined Arthur and the mother as a caretaking coalition that had been protecting Mae most of her life. There was a hint that this had been the covert marriage contract—the mother would take care of Arthur if he would help take care of Mae. Mae’s mother became angry and tearful at this. Ann and Hazel got the sister to join them in recognizing Mae’s mother as the most important person in Mae’s life in many ways. They refocused the meeting on the present: How did everyone feel about Mae’s getting a job and having a life outside the house? The family expressed fears that she would get sick again. The team asked them all to think about how Mae had reacted to being at the day center, where she had taken on several jobs and been quite responsible. They ended the meeting with an empathic exchange with Mae’s mother, telling her they understood her feeling about Mae’s needing her special care.

Two weeks later, after the center had a clothing sale of which Mae was treasurer, everybody agreed that she could leave the center to look for a job. The meetings with Arthur and Mae had produced greater candor in their exchanges with each other, but they seemed to be stuck in a rather sterile, empty world. They agreed with some trepidation to join a couples group which was conducted once a week in the evenings by Ann, in cooperation with Alex, a photographer who was a volunteer on the Service.

During the next 6 months: Mae got a part-time job as a cashier in a restaurant where one of the women in her women’s group worked. Arthur and two of the other husbands in the couples group agreed that women’s liberation was bad for their children. Ernest, Mae’s and Arthur’s son, was arrested for possession of marijuana and released. Arthur told the group he was surprised Mae did not “go off” as a result of this but, indeed, rose to meet the crisis. Mae had to visit Arthur at his garage one day and found him with another woman. This produced a major crisis. There were extra family meetings; Arthur refused to come to the couples group; Mae’s mother went to bed with a mysterious illness, and Mae spent a week with her sister. At length, Arthur agreed to return to the couples group. At the meeting of the group to which they returned, Mae and Arthur told their story. There was a general discussion of infidelity and what it might mean or had meant to the several couples in the group. The group talked about it as something that happens sometimes but that is redeemable. Ann and Alex made the point that infidelity, like psychosis, appears in families at times of change and stress. Mae took some satisfaction in all this, and seemed to feel that a score had been settled. She and Arthur returned to living together in an uneasy truce.

A year after this, they had stopped attending the couples group and Mae appeared at the day center only for medication and for chatting with Hazel. One day Mae’s sister called Hazel and said that Mae had quit her job and was sitting at home staring. Arthur and her mother were conferring about what to do. Hazel called a meeting of the whole family. Mae looked as she had at the first meeting on the ward almost 2 years before, but managed to say she had quit her job because she thought she had seen Arthur and one of the waitresses together.

Exploration revealed that Arthur had been spending a lot of time away from home, but he insisted he had been working extra hours to pay off some debts. The team pointed out to him that he had not discussed this with Mae and that she had not asked him about it. Mae had also stopped her medication.

Another meeting was needed to get Mae started on medication again, back to her job, and attending the couples group with Arthur. The group was glad to see them, and there was an exchange of stories between the couples about patterns of relapse and how to handle them, the importance of medication, and the role of the spouse in the patient’s illness. The group felt very expert in these areas since they had a great deal of experience, and Arthur told Ann there were some things about mental illness she would never understand because she had not been through it firsthand, as he had.

I have told the story of Arthur and Mae Franklin at length because it illustrates a number of points:

1. The Service was able to shift Mae quickly from the inpatient ward to the day center—without bureaucratic hangups and loss of information or control—solely because it was the better treatment. This kind of rapid choice between treatment options is indispensable.

2. The day center design requires that counseling work with the family, the interaction between the patient and the family, and the patient’s experience in the day center all be in progress at the same time and that they be presided over by the same clinical staff. This produces a maximum of information, the kind of clarification of the environment that I mentioned earlier in this article. Attendance at the day center cannot be fruitful, and will not last long, without concurrent family therapy, at least
to the extent of keeping the staff informed of what is happening in the rest of the patient's world. Conversely, family therapy for a case like this without the additional structure and experience of day center activities is a lost drop in the bucket.

3. The aim of this many-dimensioned therapy effort is to stabilize the patient's social environment by adding elements to it (day center, job, multiple family group) that can buffer the feedback circuits in the family. An example of such a feedback circuit is: Arthur is absent—Mae withdraws—Arthur consults her mother—mother visits to see if Mae is “going off” again—Mae feels another woman is plotting with Arthur—this contributes to Arthur's absence or distance from her, and so on. We arbitrarily designated this sequence as beginning with Arthur's absence because that was the easiest thing to identify and change, and Arthur was the easiest person to make responsible, not because that is where the cycle definitively started. We do not try to reverse or stop a sequence. We only want to damp its swings and avoid the next hospital admission that is part of its later and wider excursions.

4. More distant and stable members of the family, like Mae's sister, are brought in from time to time to reinforce the buffering effect and to implement the interventions of the team with overinvolved members such as Mae's mother. Note that it was Mae's sister who alerted the team for the second crisis intervention. This was the result of a carefully planned agreement with the whole family, an early warning system that ensured we would be called if anyone became apprehensive.

5. Hal, the psychiatrist in this system, was called in for the sparingly used exercise of medical authority. We have few psychiatrists on our Service, and they present themselves to the families mainly when someone needs to be impressed. Otherwise they help with the teaching, write prescriptions, and keep their powder dry.

6. The multiple family group is important to the maintenance of the system both before and after—but especially after—discharge. Families with a psychotic member feel freakish, isolated, and helpless, and the mere meeting with others in the same boat combats such feelings. The multiple family group provides:

- The feeling, for patients and families, of being expert about the problems of others.
- An arena for modest group and family therapy moves by the therapists.
- The demystification of the experience with psychosis.
- Perhaps most important, a context in which the staff can feel interest, pleasure, and genuine respect in their work with chronic and periodic schizophrenics. The multiple family groups constitute a subculture with values that are alternatives to the rejecting values of the larger culture.

A Chronic Case

Angelo Fiore

Angelo, the second child of five born to Mr. and Mrs. Anthony Fiore, is now 34. His father has been a bail bondsman for the last 5 years; before that he was a barber. Angelo's older brother, Jack, is a policeman, his younger sisters Maria and Louise are both married to construction workers, and his youngest brother Mario, 16, is in high school. Mr. and Mrs. Fiore live with Mario in a two-family house, the upper floor of which is occupied by Mr. Fiore's mother and father. All Mr. Fiore's children live within 6 blocks of this house—that is, all except Angelo who, when we first took over the Family Service, had already lived in Bronx State Hospital for the 8 years since it was built. Mr. Fiore had him moved there to be close to the family. Before that, Angelo had been in Rockland State Hospital since he was 20.

Prior to his hospitalization in Rockland State, Angelo and his family had been through a long nightmare of psychiatric experiences. Before he went to school he was treated for what seemed to be petit mal seizures. He was slow to develop, sensitive, irritable, and withdrawn. In the first grade he was found to be retarded and was transferred to a special school. The diagnosis of retardation was dropped 2 years later, but he remained in the special school because of behavior difficulties that the regular school could not manage. It is not clear what these were, but Mrs. Fiore's recollection is that other children in the school and the neighborhood used to pick on Angelo. It was for this reason that she first started to keep him at home when he was 8. There followed a series of encounters with truant officers, school psychologists, and
child care agencies, with many different recommendations. By the time he was 10, the family was reluctantly convinced that he was ill and needed treatment. He was spending most of his time in his room playing quietly. There were family battles over the long periods he spent in the only bathroom, and his mother became his primary defender as well as his caretaker.

Of several possible treatments, the Fiores chose the one recommended by the family doctor: visits to an aging psychiatrist with an office in the neighborhood. This doctor gave Angelo injections, probably of vitamins, once a month for the next 3 years. Angelo became his mother's cross to bear, and the other children were lectured by their father when they made fun of him or attacked his privileged status.

When Angelo was 14 he discovered movie magazines and pinups, of which he acquired a large collection. He spent a lot of time masturbating and began to make obscene remarks to his sister's friends. This resulted in a great deal of worry and argument and consultation with the psychiatrist, who administered two electric shock treatments.

Angelo would not return to that psychiatrist, but became much calmer and spent a lot of time watching television. He began to lose weight and appeared to be kneeling in prayer for an hour or two before going to sleep. One night in his 16th year, shortly after his younger brother Mario was born, he attacked his mother as if to strangle her, and after a long consultation with the whole family his father reluctantly presented him for the first time to the city hospital emergency room.

He was admitted, stayed for 3 months, and was discharged, having failed to establish any rapport with the resident who had tried to begin individual therapy with him. More of these “attacks” on his mother followed at intervals of a few months. They soon acquired an almost ritual character. Angelo would give warning by pacing the house and muttering, and his father and brother Jack would “watch” him, yelling instructions to each other. Angelo would eventually lurch at his mother, and the men would restrain him. There would be a hasty consultation, a trip to the emergency room with the mother in tears, and an injection of Thorazine after which everyone would go back home. Any suggestion that he be admitted was met with increased weeping from his mother and an explanation from Jack that the family “knew how to take care of him.”

As we noted, Angelo was sent to Rockland State Hospital when he was 20. Both Jack and Maria were to be married that year, and Louise planned to become a nun. Mario, then 4, was home from the hospital after open heart surgery and was taking up much of his mother's attention. Angelo had another “attack,” and this time when he informed the emergency room resident, as he often had before, that he wanted to kill his mother, the family saw the threat as real and asked that he be committed. His mother screamed and cried as before, but she had Mario to look after. Jack and her husband were very firm with her, and Angelo was shipped to Rockland the following week.

The next 12 years were monotonous for Angelo, both at Rockland and Bronx State Hospitals. He visited home about 2 weekends a year, but was brought back early if he or his mother showed any interest in his staying. He still spent a lot of time in the bathroom and paced the halls in a regular way. His main interest became the afternoon soap operas on television. He established a territory in front of the ward television set and fought off anyone who wanted to watch the quiz shows instead. He had a delusional love affair with one of the heroines and enjoyed talking to the staff about her. He read teen-love comics, which he bought in whatever quantity he could afford.

The Family Service acquired Angelo when it took over the catchment area in which his family lived. For him, as for all the patients we inherited, we held a series of conferences to assess the possibility of placing him in the community so that he could have some expectations of life larger than those which faced him in the hospital. In Angelo's case, the staff noted that he was no trouble to have around; he performed the routine of the ward with great punctuality, and even had a dim sense of humor, which he applied to the interactions of his fellow patients in terms from the teen-love comics.

Previous attempts to discharge Angelo were noted in his record; all had failed because the family protested that he would destroy his mother. It was observed, however, that he had never struck anyone in the hospital, although he sometimes behaved threateningly. Placement in a foster home had never been tried. The decision was made to explore placement in a foster home, to be supplemented with some kind of day activity, possibly in a sheltered workshop situation.

At this point I will have to edit Angelo's story very strictly, since it details an epic struggle over the following year and a half, and I want to concentrate on the
“family” aspects of this battle. But a summary of some events from this period is relevant: A group of patients like Angelo was formed on the ward—patients who needed to learn new skills applicable to the outside world. They called themselves the “Gateway Group,” and with the ward staff they practiced things like taking the bus, going to the Welfare Department to be interviewed, playing games, and making activity decisions for the day. Discharged patients already in foster homes were part of the group, and there was much charged discussion of “life outside.” The mere setting up of such a mixed inside-outside group, and the planning and administrative politicking needed to keep it alive, occupied enormous amounts of staff time. Marjorie, a nurse, and Carol, a social worker, were managing this enterprise from the outside, and Evelyn, an ATA, was running the group and keeping the hospital staff informed from the inside. Marjorie and Carol did battle with city and state foster care agencies for control over the selection and monitoring of both the patients and foster families. Transportation, funding, and medical clearance—everything that had to cross the boundary between the hospital and the outer world—were ridden with bureaucratic mischief and frustration. It was as if some mysterious force was preventing anything from crossing that boundary, even as everybody was talking about “rehabilitation” and what a good idea it was.

To return to the Fiore family’s role in this scenario, a meeting was called to discuss the prospect of Angelo’s living outside the hospital. Present at this and at most subsequent meetings, were Angelo, Mr. and Mrs. Fiore, and Jack, now 36 and just promoted from patrolman to sergeant. Angelo, who before had been tentatively interested in the idea of placement, was unable to talk about it in the meeting and kept changing the subject by asking Jack irrelevant questions. Jack and his father were polite but evasive, and the mother started to cry just before the meeting ended on a note of postponement. The team (Carol, Marjorie, and Evelyn) had agreed to introduce the family to the prospective foster family as soon as one could be found.

The family they decided on, Mr. and Mrs. William Archer, were, like most of the foster families in our part of the Bronx, urban blacks who owned a well-kept house from which their older children had departed. There was a bedroom with two beds and a separate bath on the third floor; Harry Kraft, another patient from our ward and member of the Gateway Group, was already living in it. Evelyn recalled that Harry and Angelo had gotten along well together on the ward. Mrs. Archer had worked in a nursing home as an attendant before her last child, Winston, was born. Winston was now 14 and took up a large amount of her time because he was mentally retarded. He lived on the second floor of the house with his parents. Mr. Archer worked nights at the post office and slept until midafternoon, so that the house had to be quiet. Mrs. Archer took Winston out with her on errands on weekdays, and since she did not want to leave Harry at home it was essential that he have the Gateway Group’s day program to attend. This was the household that Angelo, Evelyn, and Marjorie went to visit twice before the next family meeting with the Fiores.

Angelo surprised everyone by conducting a very businesslike discussion of the TV privileges—hours, programs. He had already talked with Harry about this matter, and it was clearly a potential source of conflict. The Archers seemed very gracious and obliging. Mrs. Archer laid down rules, mostly about meals and the use of the kitchen. At the second meeting it seemed that Angelo’s main reservation was that he would be en route to the Archer’s on the afternoon bus at the time of his favorite TV program.

At the family meeting that followed, Mr. Fiore protested at length that their doubts about the foster home idea had nothing to do with the Archers’ color, but with the lack of professional staff present. He asked what would happen, for instance, if Angelo should get sick in the middle of the night. The Fiores patiently attended three more such meetings at which race, health, activity, violence, TV, and other issues were dealt with reassuringly by the team. The schedule of activities and hospital contacts was reviewed in detail. Angelo said less and less, and Mrs. Fiore wept at the end of each meeting and would not say why. It became clear to the staff that the Fiores were in polite ways comparing the Archers’ home to their own and saying essentially, “These people could never take care of Angelo.” Carol finally suggested that it would upset the Fiores if Angelo lived with another family when they had decided he couldn’t live at home. Angelo promptly got up and lurched toward his mother; Jack restrained him, and his mother burst into tears. Mr. Fiore pointed to this as proof that Angelo was too sick to leave the hospital, Angelo said loudly that he didn’t want to live with a bunch of niggers, and the meeting broke up.

Carol then met with Mrs. Fiore alone for a while, going over the history and talking over Mrs. Fiore’s feelings about Angelo. Meanwhile, two State senators and the
attorney general wrote the hospital director, objecting to Angelo's proposed discharge. This required a lot of traffic with the hospital director's office, including a conference and a written report. The team psychiatrist telephoned Jack and told him the family's political tactics were not going to work and offered to discuss the problem with the family directly.

Meanwhile, the relationship between Carol and Mrs. Fiore progressed to the point where Mrs. Fiore was willing to meet with Mrs. Archer. Evelyn and Marjorie, who knew Mrs. Archer well, prepared her for the meeting. The two ladies talked about their sick children, Mrs. Archer was very reassuring, and Mrs. Fiore gave permission for Angelo to visit there for a weekend. Angelo, however, had stopped attending Gateway meetings, and the staff felt that he and Harry should first make contact again. They finally did so, and Harry escorted Angelo to the Archers' for a meal and an evening of TV.

A year later, Angelo was living at the Archers' and had just graduated from the Gateway Group to the hospital's sheltered workshop. The year had been marked by ups and downs in relations between the team, the Archers, and the Fiores, with Angelo being pulled toward the various corners of that triangle as he settled down to his new way of life. A typical sequence went like this: Angelo would go home for a visit; his mother would cry. Angelo would decide he wanted to live at home and would not return to the Archers' ; Mr. Fiore would phone Marjorie to say Angelo was too sick to be out of the hospital; Marjorie would refuse to take him back into the hospital and would tell him over the phone to return to the Archers' ; Jack would bring him to the hospital where the night physician would admit him; Angelo would escape and show up next morning to yell at his mother; Marjorie would make a hurried home visit and drive Angelo back to the Archers' ; the team would smooth things over with the Archers, who were angry and frustrated; there would be a meeting of Carol, Marjorie, Mrs. Archer, Mr. Fiore, and Angelo to rehearse again everyone's feelings about Angelo's living at the Archers'. The eventual ending of this tug-of-war was aided by the Archers' attending a multiple family group of foster parents run by the team, to which such parents could take their problems and where they could get mutual support and a sense of communal expertise. The Fiores refused to attend any meetings that were not specifically about Angelo, so they were not part of a multiple family group. Another intervention that may have been decisive occurred when Mr. Fiore's father died and his mother was alone in the upstairs apartment, bedridden with pneumonia. Carol got visiting nurse service to help Mrs. Fiore care for her mother-in-law at home and in various ways promoted Mrs. Fiore's status as a strong, indispensable person in time of trouble. This reduced her tearful anxiety over Angelo.

The routine of life finally settled down for everyone, with Angelo leaving the Archers' every day for the workshop with a brown bag lunch he made himself after breakfast and returning in time for the last soap opera of the afternoon. His mother visited him on Sunday afternoons, and he went to his family on holidays.

The story of Angelo's placement in a foster home is fairly self-explanatory, but some points should be brought out:

1. The objective here is placement in the literal sense of putting the patient in the best available context for his gradual development—that is, for the acquisition, at his own pace, of some of the social skills of an independent citizen. This is the most he can expect of life. That kind of judgment is made at the outset; repeated experience has told us that greater expectations for patients like Angelo lead only to frustration for everyone, especially for the patient himself. There is evidence that chronic patients like Angelo make better adjustments out of the family and out of a hospital, in sheltered, limited contact with both the world and the family. A good foster family provides guilt-free objectivity, along with warmth and consistency, for a balanced emotional environment (Mechanic 1969).

The placement of patients like Angelo is no small trick, and I have tried to show here that it requires vigorous work with the family and with an extended network of others. The unstable triangle of family, patient, and foster family, if left to its own tendencies, will force the patient back into a hospital, where he will have little chance to develop, even slowly.

2. The job of our Service, then, is to construct in the interstices of the workaday community a place (Sanders 1972), a second, more tolerant community that consists of the sheltered workshop, the Gateway Group, the foster home, a halfway house (if we had one), the special floor of a hotel (if we had one of those)—a niche where people like Angelo can live and have some access to the opportunities of the open world, as the rest of us do.

Protecting this kind of inner-shell community from the ravages of the outer world is hard work. It is much harder
than running a hospital, but it is better for everybody, since it keeps them—staff and patients and family—more alive to each other.

Clearly, all these services must be under the same administration and must be smoothly coordinated. To parcel them out to different agencies is simply to ensure their failure.

Conclusion

In each of these stories, families existed and were willing to be involved. The patients were not very threatening or forbidding people, though they each had quite different temperamental and social endowments. All the families were comfortably well-off. Each of the stories would have been different—with many of the gains far more difficult, or impossible—with violent patients, actively uninterested or absent families and poverty as part of the background.

Of all these complicating factors, I will say a word here only about uninterested families. We don’t take a family’s lack of interest at face value; sometimes it is necessary to discharge the patient to his home to find out how interested a family really is. And when a family is presenting a member for admission, we make a clear contract at the front door, stating what we will do for them and what we expect from them by way of participation and help. Our position as hospital of last resort gives us a wedge in these negotiations, but we have to expect a certain amount of political flack such as we had from the Fiores.

Research—The Need for New Classifications

By now it should be clear to the reader that we regard the success of our operation as a complex interaction of the patient’s constitutional endowment and the family and social context that has been provided for its development, of which previous psychiatric treatment is a very important part. There are ways of studying all these factors, of seeing how they fit together, that enable the constructing of a group of typical careers with many more examples than the four I have put together here. But there are only a finite number of kinds of stories.

In order to understand the factors in relation to the careers, we need to go beyond our present individual diagnostic approach to the classification of patients, and to classify instead the lives of patients in family, economic, and treatment contexts. It is a job for sociologists and cultural anthropologists with a bent for classifying people in terms of their interactions with the culture. The record keeping system of a service such as ours, if reorganized to provide systematic social information, would be applicable to this task. Anyone listening closely at our case conferences would soon discover that this is the information the staff actually uses to make plans and predictions about patients—they reserve the psychodynamic and diagnostic incantations for the charts and the professors.

Staff

I will conclude this paper with a word about the staff of the Family Service, since there are thoughts about this that I want to underline in the memory of the reader. Here I have in mind especially the legislative, administrative, and budgetary reader who determines the conditions of work and recruitment.

I have said throughout this paper that many aspects of the lives of the patients and their families must be kept in mind if the treatment is to succeed. The same thing is true of the staff members and their lives and contexts. Treatment of this kind—perhaps all psychiatric treatment—is not limited merely to the hour or day during which the staff and patient are in contact. That contact is actually the touching of many tangent circles—whole lives in progress—that are implied though not seen in the “treatment situation.”

People in other fields often ask, “Why would anyone want to spend his life working with schizophrenics?” or “How do you keep from getting discouraged or going crazy yourself?” These are good questions—they imply a recognition that people do not go into this kind of thing as one might go into manufacturing or the Internal Revenue Service. And rather than speak of “motivations” for this kind of work (we have learned that “motivation” is a slippery notion in complex social fields), I prefer to continue to speak of careers in context, since those are much more observable, whether we are talking of patients or staff.

Unfortunately, many departments of mental hygiene treat the careers of our staff members as if they were just like any other jobs in a bureaucracy. I have said above that bureaucracy as a form of social organization is lethal in its effect on treatment organizations such as ours. This is interrelated with the bureaucratic individual’s career.

A bureaucratic career in mental health is one in which the long-term expectations are those of bureaucratic careers in general—security, increasing hierarchical responsibility with increasing salary, job assignment on the basis of the Civil Service examination, and eventual
risk taking, subversive politicking, minor rule breaking, must be able to retreat sometimes. No one can do this action—that is an exhausting personal encounter. One defeated, the finding of some way to redefine a situation constant facing of defeat without becoming personally upsetting people and their families. It is a way of keeping patients and their lives at arm's length from the staff and presentable to the outside world.

I have described in this paper the kind of imaginative risk taking, subversive politicking, minor rule breaking, and bending of conservative institutions that is required to do social and family management of schizophrenia. The kind of work we do is incompatible with the bureaucratic career, beginning with our most basic priorities.

There are non-bureaucratic careers that don't work, of course. The "angel of love and mercy" career and the Laingian cultural revolutionary who thinks that "crazy is better" because the madman sees to the heart of things—these cannot survive contact with the real world of schizophrenia, and they burn out as they enter its atmosphere. But I want now to return to the question, What are the career expectations that enable people to work with schizophrenics and their social systems?

This is not easy to answer, because diversity is the first key to what I want to describe. People who work well in our organization are a very mixed lot. A good treatment team is an association of all sorts of men and women, respecting each other for the peculiar contribution each is able to make to interaction with the families and patients. We have had gay graduate students, stuffy suburban matrons, nonstuffy suburban matrons, black labor leaders, men and women with criminal records, ex-nuns, black and Puerto Rican State Hospital ATA's, and, of course, pipe-smoking psychologists. The important thing is that all are working together to make whatever contribution they can to this work, at this period in their lives, according to their talents and limitations.

However diverse these individuals, each of their careers is primarily a personal quest. I have never met anyone in this business who was not dealing, in one way or another, with his own private understanding of human hope and despair—often trying to deal with it as it has been reflected in his own life. The intensity of this work, the constant facing of defeat without becoming personally defeated, the finding of some way to redefine a situation to include the possibility of hope and constructive action—that is an exhausting personal encounter. One must be able to retreat sometimes. No one can do this work all week long or every year of his life. The working life of the staff must include times of rest and reflection. Otherwise they get “burned out”—permanently turned off from too much coping.

People who are really effective in this work are able to keep going because they see it as part of their own development. I don't mean just their professional development—although they do learn skills and get degrees that are useful later. The personal development is much more important. Most members of our staff—or at least those whom I have gotten to know well enough to talk with them about this—have had their own brush with psychosis, either in themselves or in a relative or in the way they look at the world, and they are trying to view the experience through that window which sometimes turns into a mirror. The therapist as a seeker, sometimes of himself, is a feature of most good therapeutic communities (First 1974). I want to emphasize that this is not just a romantic description of us all. I mean that time for training, learning, reflection, meditation, and mutual teaching and encouragement is a necessary condition of this kind of work. It is more important to productivity than money.

Development implies change. Almost nobody works for more than 5 years at the same role without feeling he has outgrown it. Ten years is a very long time for any group to work together without a total change of both leaders and followers, teachers and learners. Being able to pass from learning to teaching or on to more effective practice, and finally to the discovery of the real gift you can give to this kind of work, is the change everyone works toward. You may have to go somewhere else to discover your gift. In fact, people who have gone elsewhere are one of our most important products; we must not regard them as a loss to the organization.

To restate the above paragraphs in hard personnel policy terms, I have been talking about: criteria of employment; salary levels in relation to qualifications; provision for time-off, study-leave, in-service training, and flexibility of job assignments; the funding of teaching and training items as part of the service budget; and leave-taking and pension practices that make it easy to come and go. Administrators usually think of these as "fringe benefits" or concessions they have to make to the staff; and they worry about the staff's becoming too lazy as a result of soft policies. I have been trying to make it clear that in professional work with schizophrenics these soft policies are the key to hard productivity.

To those uneasy administrators, I want to direct a final word about rigor. The things that hold this kind of
organization to a high work standard are: 1) an exact idea of what we are trying to achieve; 2) the freedom to invent new ways to achieve it; 3) a precise record system to tell us how we are doing; 4) a research design that reevaluates our work from year to year; and 5) theories or ideas that provide us with our own conscience as we test our experience. If we can be left alone with these tools, we will deliver as best as we can.

Leaving us alone, of course, is difficult for most administrators. What will make it easier is a reliable scoreboard that both we and the administrators can consult. That is what I mean by a precise record system, and by the call for research to develop classifications more precise and valid than those we now use. Such a scoreboard is the key to the accountability of this system.

When a staff generates its own accountability, deals successfully with its own and the patients' social and political problems, and contributes to its own personal growth, then it can do a commendable job of looking after patients and their families.

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