A View from Riggs: Treatment Resistance and Patient Authority—IX. Integrative Psychodynamic Treatment of Psychotic Disorders

Jane G. Tillman

Abstract: Psychotic spectrum disorders present treatment challenges for patients, families, and clinicians. This article addresses the history of the dualism in the field between biological and psychological approaches to mental disorders, and surveys the contemporary literature about the etiology and treatment of psychotic spectrum disorders. An integrative approach to treatment derived from work at Austen Riggs with previously treatment refractory patients with psychotic spectrum disorders is described that combines individual psychodynamic psychotherapy, psychopharmacology, family systems approaches, and intensive psychosocial engagement. Helping patients develop their own authority to join the treatment, use relationships for learning, and understand the meaning of their symptoms is central to the treatment at Austen Riggs. An extended case vignette of a patient diagnosed with a schizoaffective disorder is presented illustrating this integrative psychodynamic treatment approach.

Psychotic spectrum disorders present major challenges to patients, families, and clinicians. Medications have succeeded in providing many patients with relief from the positive symptoms of the disorder, such as delusions, hallucinations, or mania, and atypical antipsychotics may even help some negative symptoms. But even when symptom suppression has been achieved, clinicians, patients, and their families are left to try to put together the pieces of a life devastated by serious mental illness. The person suffering from the aftereffects of a psychotic episode still has a life to live while coping with the effects of his or her illness and the meaning of his or her symptoms. Often, because of the severity of the trouble, the relapsing and remitting course of the disorder, the limitations of medications, and the upheaval in interpersonal,

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occupational, and social functioning, these patients become among those considered "treatment resistant."

Psychoanalytic or psychodynamic psychotherapy as a treatment modality for psychotic spectrum disorders remains a source of controversy, both within biological psychiatry and the field of psychoanalysis. The American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia (2004), which recognizes that fully a third of patients with schizophrenia fail to respond adequately to antipsychotic medication, endorses cognitive behavioral therapy (CBT) for patients with schizophrenia but not psychodynamic psychotherapy. In the field of psychoanalysis, most training programs have removed courses on the treatment of psychotic disorders from their curricula (Gottlieber, 2006), finding that these patients present too great a challenge for insight oriented analytic work. The dualism between biology and psychology is often magnified when approaching the treatment of psychotic disorders. How one thinks about the etiology of psychotic disorders often determines the treatment modality. In the current zeitgeist of biological psychiatry, psychological factors that may either mitigate or promote symptom expression are often overlooked, and psychotherapy, if prescribed at all, is subordinate to the biological perspective.

At the Austen Riggs Center 10 to 15% of our patients struggle with psychotic disorders, many of which have become "treatment resistant" over time. Given the current preeminence of biological treatments in training and practice, many of these patients are essentially psychotherapy naive at the time of their admission, having tried numerous medications but having had relatively little sustained intensive psychotherapy or other psychosocial interventions. Our treatment model at Riggs closely parallels the "need-adapted treatment" described by Finnish researcher Yrjö Alanen, a treatment tailored to the specific needs of the individual with schizophrenia, using psychodynamic psychotherapy, family systems work, medication, and community support (1994a, 1994b, 1997a, 1997b; Alanen, Lehtinen, Räkköläinen, & Aaltonen, 1991). Practicing in the complex system of the Austen Riggs Center presents an opportunity to authentically integrate biological perspectives, sociocultural factors, individual dynamics, and family systems psychodynamic processes. As noted throughout this series of articles, the Riggs treatment approach emphasizes three major psychosocial issues in work with treatment resistant patients, including those with psychotic disorders. These issues include an emphasis on the authority and voice of the patient, the centrality of relationships in the process of recovery, and the importance of unearthing the meaning of symptoms, of illness and of treatment resistance itself.
This article will first review the history of the dualism between the biological and psychological theories of psychotic disorders. After surveying contemporary research related to the etiology and treatment of psychotic spectrum disorders, this article then offers a description of the integrative approach used at Riggs to treat these patients. The usefulness of psychodynamic psychotherapy, when embedded in a larger context of a therapeutic community for psychosocial learning (Elmendorf & Parish, 2007), a psychodynamic psychopharmacology approach to prescribing (Mintz & Belnap, 2006), and family treatment (Schwartz, 2007) is examined. All of these psychotherapeutic approaches are grounded in Muller's (2007) sophisticated concept of the Third as a structuring function and external referent for staff and patients in our work together. I will advocate for a both/and approach to the treatment of psychotic disorders rather than the historical and now contemporary either/or approach regarding biological and psychological therapies. Finally, I present case material illustrating the comprehensive approach to the treatment of a patient with a psychotic disorder within the open setting of the Austen Riggs Center.

HISTORY

Biological theories about the cause of mental illness have their roots in ancient traditions. Hippocrates offered a theory of four humours to account for changes in personality or the presence of illness in his patients. When the four humours of black bile, yellow bile, phlegm, or blood were out of balance, patients might present as depressed, melancholic, hot tempered, amorous, or unemotional. Such theories of "chemical imbalance" have remained popular since that time. With the neoclassical revival in 18th century Europe, ancient theories led to such treatments as applying leeches or blood letting by other means to try to rid the body of toxins or excesses. The film The Madness of King George (1994) has a dramatic scene of cupping the back of the king in an effort to treat his severe mental illness, now thought to be a manifestation of acute intermittent porphyria.

Moral therapies for psychiatric disturbance became popular in the late 18th century as well, after thinkers such as Kant popularized the notion of individual rights and responsibilities, and Rousseau offered the notion of the social contract as an ordering principle for balancing the conflict between the individual and society. Such theories are still evident in contemporary therapeutic community practices. As a result
of the work of these early thinkers moral therapy for mental illness became more common.

In 1882, the German physician Robert Koch reported the discovery of *mycobacterium tuberculosis*, providing a biological marker for one of the most feared diseases of that time. Infected people could now be identified, isolated, and treated with rest cures and other medically directed but morally tinged therapies. Within the medical community great enthusiasm surfaced for finding a bacteriological basis for many human illnesses. Psychiatry, a newly formed medical specialty at the close of the 19th century, also aspired to identify the biological/bacteriological basis for mental illness.

The rift between biological and psychological theories and treatments deepened throughout the 20th century. Andrew Scull (2005) gives a harrowing account of the supposedly scientific zeal of Henry Cotton, M.D., the superintendent of the Trenton State Hospital from 1910 to 1933. Enthused by Koch’s discoveries related to tuberculosis, Cotton surmised that the “functional psychoses” were caused by “focal sepsis” that was bacteriological in origin and could be treated surgically. He spent his tenure at the Trenton State Hospital attempting to cure the psychoses by extracting the teeth, colons, uteri, gallbladders, and other organs of his patients, many of whom died in this pursuit. The data Cotton collected and reported in journals and at professional meetings was later found by a young psychiatrist, Phyllis Greenacre, to have been fabricated and misinterpreted (Scull, 2005). Scull reports that Greenacre’s description of Cotton’s scientific misconduct was suppressed by Adolf Meyer and Cotton was never held accountable for the enormous harm he caused to thousands of psychiatric patients entrusted to his care.

If Cotton’s story is one of the most gruesome, it is certainly not the only example of some overzealous but misguided physicians injuring or maiming their patients in an effort to cure psychotic disorders. Insulin coma, deep hypothermia, lobotomies pioneered by Egaz Moniz and Walter Freeman, Metrazol induced seizures, and other somatic therapies were applied in a variety of situations, often without informed consent. Psychologically traumatized World War I soldiers were subjected to severe electrical shocks of the pharynx, forehead, and other parts of the body in an attempt to cure them of “malingering” by a 1927 Nobel Prize winner in medicine, Julius Wagner von Jauregg, a contemporary and, at times, an antagonist of Freud in Vienna.

Contemporaneous with the focus on drastic somatic and surgical therapies for psychotic disorders, Ernst Simmel, a young psychiatrist in the Prussian army during World War I, petitioned the government to create a psychoanalytic hospital for the treatment of the war neuroses. While this did not happen immediately, by 1927, with the help of
his colleagues at the Berlin Polyclinic, the Berlin Psychoanalytic Society, and the endorsement and help of Sigmund Freud, Simmel opened the first psychoanalytic hospital, the Schloss Tegel sanitarium, which functioned from 1927 until 1931. The patient population of this hospital included severe alcoholics and patients with character disorders, and likely higher functioning psychotic patients. Extending psychoanalytic treatment to a hospitalized population of seriously disturbed individuals introduced the element of group phenomena. This gradually evolved elsewhere over the next several decades into the development of therapeutic communities and milieu treatment as adjunctive to the psychoanalytic task.

Karl and Will Menninger visited Simmel in the 1930s, seeking his consultation about their pioneering psychiatric hospital in Topeka, Kansas. Trained as psychoanalysts, they sought to develop a hospital based on psychoanalytic principles, but with greater flexibility to allow for the treatment of psychotic patients. Here, classical psychoanalytic technique was modified based on the assessment of the patient’s capacity to work in such a treatment modality.

Parallel to the ongoing developments occurring in biological psychiatry, progressive adaptations of technique were occurring in psychoanalytic circles allowing this method of treatment to be extended to a more troubled population. With the end of World War II the need for psychiatric services for returning veterans was apparent. In this context, the Menningers founded the Menninger School of Psychiatry in a partnership with the Veteran’s Administration Hospital in Topeka. One Menninger Clinic psychoanalyst, Robert Knight, M.D. left Topeka in 1947 to become the Medical Director of the Austen Riggs Center in Stockbridge, MA, bringing with him such luminaries as Roy Schafer, Margaret Brenman-Gibson, David Rapaport, Merton Gill, and Alan Wheelis. Knight’s interest in articulating a theory and treatment for borderline conditions led him to contribute to the discussions of the time about the widening scope of psychoanalysis.

With the well-documented disasters of biological psychiatry (El-Hai, 2005; Scull, 2005) becoming apparent by the late 1940s, psychoanalysis stepped in, developing hegemony in American academic psychiatry and hospital treatment. Theories about the etiology and treatment of schizophrenia were developed, but were difficult to test empirically. Clinicians from the interpersonal tradition of psychoanalysis led by Harry Stack Sullivan, Clara Thompson, and Frieda Fromm-Reichmann, began treating schizophrenic patients at the Chestnut Lodge Hospital in Maryland using primarily psychoanalytic psychotherapy. In a 1948 paper, Fromm-Reichmann posited that a potential contributor to the development of schizophrenia could be traced to the “schizophrenen-
genic mother.” This was an attempt to locate the etiology of the psychoses in the earliest relationships. While these theorists were often accurate in many of their observations about schizophrenic social and family dynamics, terms like “schizophrenogenic mother,” or “refrigerator mother” (in the case of autism) have a tone of mother blaming, to which there has been an understandable backlash, and also proved difficult to validate with empirical research findings. When Otto Will became the medical director of the Austen Riggs Center in the late 1960s he brought from Chestnut Lodge a psychoanalytic theory and technique for treating schizophrenic patients that had been practiced there for several decades.

The role of the mother as a contributor to the development of severe psychopathology enjoyed a dubious psychoanalytic career from the 1940s until the mid 1970s (Neill, 1990; Willick, 2001). The mother as a protective agent facilitating the infant’s and child’s development was more central to the work of Winnicott and provided a counterbalance within psychoanalytic thinking. Like biological psychiatry, developments and advances in psychoanalysis were often accompanied by authoritarian statements about cause and cure that went beyond the bounds of good practice. While many in the psychoanalytic community resisted the use of medication in treating their patients, over time it became apparent that for many patients combined treatment was superior to either medication alone or psychotherapy alone. There were notable exceptions, where psychodynamic psychotherapy alone produced symptom remission and therapeutic gain (Gottdiener, 2006), which should not be of great surprise to clinicians who have worked psychotherapeutically with patients in the psychotic spectrum who have recovered.

The hegemony of psychoanalysis in the United States “led to a significant de-emphasis on diagnosis and nosology . . . and a de-emphasis on careful observation of signs and symptoms” (Andreasen, 2007, p. 110). Without such scientific means, the systematic classification and study of the psychotic disorders was impossible. The response of general psychiatrists was to develop a more careful descriptive taxonomy of psychiatric illness in the Diagnostic and Statistical Manual of Mental Disorders (DSM). By 1980, with the publication of DSM-III, field trials of the nosology were included to demonstrate diagnostic reliability and facilitate psychiatric research about the validity of the categories of psychotic and other disorders described and their longitudinal course and outcome (McGlashan, 1983; Plakun, Burkhardt, & Muller, 1985). American psychoanalysis resisted such schematization and did not work to join the conversation early on. However, in 2006 psychoanalytic researchers and clinicians introduced the Psychodynamic Diagnos-
tic Manual (2006), attempting to articulate in a systematic way theory based psychoanalytic diagnosis. Unfortunately, the lack of field trials demonstrating reliability and validity of categories limits the potential utility and acceptance of such a manual within descriptive psychiatry.

By the late 20th century psychoanalysis was largely purged from academic medicine, while many of the long-term hospitals providing private treatment based on a psychoanalytic model had closed (Plakun, 2006). McWilliams (2000) observes that psychoanalysis has had a steady hand in its own demise through arrogance and refusal to engage in outcomes research verifying the efficacy of psychoanalytic treatment for both neurotic and psychotic disorders.

Psychoanalytic psychotherapy and intensive treatment are time-consuming and expensive. Biological psychiatry came into ascendency with advances in the field of psychopharmacology—producing medications with a demonstrated positive effect in treating such active symptoms of psychosis as hallucinations, delusions and mania, and reducing the time and cost to treat psychotic patients in the acute phase of illness. The psychotherapeutic relationship between the patient and the therapist is now often relegated to merely supportive/educational status, while medication has become the great hope for many patients, families, and doctors. Enthusiasm for scientific psychiatry was ascendant in the 1970s and continues to shape treatment guidelines in contemporary psychiatry. General psychiatry recognized the necessity of scientific research far earlier than did psychoanalytic clinicians. The field of psychoanalytic research may be characterized as idea-rich but also as methodology- and resource-poor (Reiss, 2008), and this needs to be addressed in order to continue to demonstrate the efficacy of psychoanalytically oriented treatments.

CONTEMPORARY RESEARCH ON PSYCHOTIC DISORDERS

Etiology

Schizophrenia research is difficult because schizophrenia may not be a single entity, but rather an umbrella term for a heterogeneous set of symptoms with a range of etiological factors. Biological researchers are now pursuing in great detail the neurobiology of psychotic spectrum disorders. For the past 50 years, a focus on the dopamine system has been a mainstay of neurobiological research in psychotic disorders. In any contemporary psychiatric journal one is likely to see articles related to the component symptoms of psychotic disorders full of the names
of complicated chemicals and enzyme systems. These articles are the foundation of current psychiatric bench research and clinical trials.

Other studies look at structural and functional neurobiology, neurodevelopment, and genetic components of schizophrenia. Genetic research aims to identify heritable conditions that may render a person vulnerable to developing schizophrenia. In their well-known review of adoption and twin studies, Gottesman and Shields (1976) noted that in monozygotic twins, the concordance rate for schizophrenia was between 35 to 58%, compared with dizygotic twins, where the rate was 9 to 26%. This research suggests that it is possible for an individual to carry the same genes as someone who develops schizophrenia without ever developing the illness, suggesting that genes play a significant but not exclusive role in the pathogenesis of schizophrenia.

In a long-term follow-up study of Finnish adoptees, researchers compared the offspring of schizophrenic mothers who were subsequently adopted, to adoptees without a genetic risk for schizophrenia (Tienari et al., 2004). The adoptive families were rated for levels of function or dysfunction. In the high-genetic-risk group there was a significant association between family dysfunction and the adoptee being diagnosed with a schizophrenia-spectrum disorder. The demonstration of this genotype-environment interaction led the authors of this study to conclude that neither high-genetic-risk nor dysfunctional family environment alone account for the development of schizophrenia-spectrum illness. Findings of a clear interaction effect support a stress-diathesis model of psychopathology.

Williamson (2007) notes, "the last two decades have been marked by a concerted search for the gene or genes which would account for schizophrenia. It has become increasingly obvious to many investigators in the field that these genes are not going to be found. Schizophrenia is not likely a simple genetic disorder nor is it likely accounted for by a few major genes" (p. 953). Researchers, however, are making progress in understanding the genetics of the cognitive components associated with schizophrenia, identifying intermediate phenotypes of heritable traits. The genetics of specific measurable cognitive functions are an important advance, but extrapolating to a diagnostic category via genetic evidence is unlikely (Goldberg & Weinberger, 2004; Tan, Callicott, & Weinberger, 2008). Overall, the evidence suggests around 50% of the variance in etiology of schizophrenia is attributable to environmental factors rather than genetics, including such environmental factors as individual dynamics, family environment, migratory status, trauma, and environmental chemical influences.

Research about the role of the environment in schizophrenia is less well known than biological research. In his review of the psychiatric lit-
erature, Jarvis (2007) concluded that there is a dearth of research related to the role of psychosocial factors in the etiology of psychotic disorders in North American journals. This regional disinterest notwithstanding, Jarvis notes our European colleagues are leading the way in psychosocial research about the etiology and treatment of psychotic disorders.

Trauma is once again being scientifically investigated for the role it may play in the development of schizophrenia. British researchers Shevlin et al. (2008) conducted a study to estimate the effect of cumulative trauma on the development of schizophrenia. Using two large community samples (one from the United States and one from the United Kingdom), they concluded that experiencing two or more types of trauma significantly predicted psychosis in a dose-response relationship. The trauma of childhood molestation and physical abuse, along with serious injury, assault and violence in the home, were significantly associated with an increased incidence of schizophrenia. Morgan and Fisher (2007) reviewed the question of whether childhood trauma is a factor in the later development of psychotic disorders. While they noted many conceptual and methodological problems with the existing research, they also acknowledged that “a small number of recent population-based studies provide more robust evidence of an association, and there are now plausible biological mechanisms linking childhood trauma and psychosis” (pg. 3). Such research may confirm the clinical experience of psychodynamic clinicians, who observe a relationship between childhood trauma and the treatment resistant symptoms of seriously disturbed patients.

Psychosocial adversity associated with migration is also associated with the development of schizophrenia (Cantor-Graae & Pedersen, 2007; Cantor-Graae & Selten, 2005). Research implicates migration as a significant risk factor for schizophrenia, where “high incidence rates for schizophrenia have been found for persons of Surinamese, Dutch Antillean, and Moroccan background in the Netherlands…and an increased risk for developing schizophrenia has recently been found for all migrants in Denmark, particularly those from Australia, Africa, and Greenland” (Cantor-Graae & Selten, 2005). Both first and second generation migrants are more vulnerable to psychotic disorders, suggesting an intergenerational transmission of trauma or sociocultural dislocation. Hypotheses surrounding the idea of “social defeat” and the discrimination that many black skin migrants face have been offered as causal pathways to the higher incidence of schizophrenia in this population. Here, empirical research validates psychoanalytic theorists positing a social link in the development of psychotic disorders (Davoine & Gaudilliere, 2004; Fromm, 2006).
Treatment Approaches

A current trend in psychiatry as in medicine is toward the development of practice guidelines promoting “evidence based medicine.” Of course, what constitutes evidence is an area of dispute. Much money and energy have been spent researching brief treatments for various disorders and on medication trials, while psychoanalysis and dynamic therapies are late to the table in this arena, are rarely funded by NIMH and other large granting agencies, and have not produced a robust body of quantitative outcome research literature.

An important study in this regard is the National Institute of Mental Health funded Schizophrenia Patient Outcomes Research Team (PORT), which was charged with developing and implementing evidence based treatment recommendations for schizophrenia. These findings greatly influenced the development of the American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia (APA, 2004). The PORT study utilized a comprehensive review of the treatment outcomes research literature to craft guidelines for the treatment of schizophrenia based on the efficacy of various treatment approaches (Lehman, Steinwachs, et al., 1998). Criteria levels for evidence were established where Level A was characterized by “good research-based evidence, with some expert opinion, to support the recommendation.” Level B evidence was characterized by “fair research-based evidence, with substantial expert opinion,” and Level C as “recommendation based primarily on expert opinion, with minimal research-based evidence, but significant clinical experience” (p. 2). Psychodynamic therapies did not fare well in this methodology, understandably relegated to level C criteria at best.

The PORT study made 30 recommendations for the treatment of schizophrenia. The first 21 of these recommendations addressed pharmacotherapy and ECT. Recommendation 22 states “Individual and group psychotherapies adhering to a psychodynamic model (defined as therapies that use interpretation of unconscious material and focus on transference and regression) should not be used in the treatment of persons with schizophrenia” (Lehman, Steinwachs, et al., 1998, pg. 7). Recommendation 23 was in favor of “individual and group therapies employing well-specified combinations of support, education, and behavioral and cognitive skills training approaches designed to address the specific deficits of persons with schizophrenia” (p. 8). Other recommendations include family treatments, but specifically avoiding those “based on the premise that family dysfunction is the etiology of the patient’s schizophrenic disorder” (p. 8). The final recommendations
address the need for vocational support and "assertive case management" and "assertive community treatment" to prevent re-hospitalization. Interestingly, the Finnish Turku project noted earlier (Alanen et al., 1991) demonstrating the efficacy of "need-adapted treatment" for schizophrenia, was not included in the PORT bibliography and does not appear to have been considered in formulating the treatment guidelines.

As you might imagine, there was a vigorous response to the PORT recommendations from psychodynamic clinicians experienced in providing effective treatment to patients with schizophrenia. At the second annual meeting of the United States Chapter of the International Society for the Psychological treatments of the Schizophrenias and other psychoses (ISPS) in October 2000, psychodynamic clinicians and the authors of the 1998 PORT study came together for an interdisciplinary discussion.

This journal (2003) published the proceedings of that meeting along with other articles to address the short shift the PORT study gave to psychodynamic psychotherapy and family treatment. Ver Eecke (2003) directly addressed recommendation 22 of the PORT study stating that psychodynamic psychotherapy for schizophrenia was contraindicated, and recommendation 26, discouraging addressing family dysfunction and its role in schizophrenia. Using empirical studies, Ver Eecke (2003) showed evidence for the usefulness of both insight oriented treatments and those addressing family conflict and dysfunction. Other authors addressed the controversies of evidence based medicine (Margison, 2003), a critique of the methodology of the PORT study (Gottdiener & Haslam, 2003), and the importance of psychotherapy in the treatment of schizophrenia (Karon, 2003). In response to these conversations, in the 2003 revisions to the PORT guidelines, Lehman and his colleagues retracted their prohibition against psychodynamic psychotherapy for schizophrenia stating:

In the updated PORT recommendations, the old recommendations that warned against certain treatments, including psychoanalysis and family therapy based upon theories of family causation have been eliminated. This revision is not because the evidence regarding these treatments has changed but rather because we made a strategic decision not to list the many treatments that have been applied historically to treating persons with schizophrenia but have now been shown to be ineffective . . . Reductionistic treatment plans that use only pharmacotherapy, or any other single modality, are inadequate from an evidence-based perspective. (Lehman et al., 2004, p. 206)
While the massive effort by this Journal was effective in removing the prohibitions against psychodynamic psychotherapy and psychodynamic family therapy, the revised statement leads the reader to assume that psychodynamic treatment is among those “historical” treatments that have been “shown to be ineffective.” This familiar error in logic perpetuates the problem of bias against psychodynamic approaches, equating the lack of evidence of efficacy with evidence of lack of efficacy. It is quite clear now that it is incumbent upon the psychoanalytic and psychodynamic communities to continue to produce evidence of positive treatment outcomes that meet the standard of rigorous research methodology in our respective disciplines.

Researchers sophisticated in psychodynamic treatment are responding to the challenge. Gottdiener (2006) reviewed the meta-analytic research on individual psychodynamic psychotherapy in the treatment of schizophrenia, concluding “individual psychodynamic psychotherapy for schizophrenia was associated with significant improvements when used with medication and even when used without medication” (p. 586). He also noted that there were fewer than 30 studies of psychodynamic psychotherapy for people with schizophrenia, encouraging researchers to develop randomized controlled trial (RCT) studies to study the efficacy of this treatment approach. The positive contribution of the PORT study in advocating for a biopsychosocial approach to the treatment of schizophrenia, and Gottdiener’s (2006) review of the meta-analytic literature supporting psychodynamic psychotherapy as a treatment modality are a guide and an endorsement of the comprehensive treatment approach used at the Austen Riggs Center.

INTEGRATED TREATMENT

Treatment of psychotic spectrum disorders has been carried out at the Austen Riggs Center since the late 1940s. Over time the treatment model has evolved into an integrated interdisciplinary approach to our patients. Our treatment may be favorably compared to the work of Alanen (1994a, 1994b, 1997a, 1997b; Alanen et al., 1991) and his Finnish colleagues in Turku who have conducted and researched what they term “need-adapted treatment.” The main principles of “need-adapted treatment” are:

1) a basic psychotherapeutic attitude, 2) development of hospital wards into psychotherapeutic communities, 3) development of family therapy and other family-centered activities, 4) development of individual therapeutic relationships, 5) appropriate use of pharmacotherapy as a mode of
treatment supporting psychotherapy, and 6) active participation of all professional groups in the therapeutic work. (Alanen, 1997a, p. 141)

In the Turku project long-term individual psychodynamic psychotherapy with schizophrenic patients was associated with a significant reduction in the days of acute hospital treatment needed over the course of 5 years (Alanen, 1997a, p. 147).

Previous articles in this series have addressed the various modalities and intricacies of psychodynamic therapy and residential treatment with patients who are often considered to be “treatment resistant.” Austen Riggs aims to integrate “best practices” in the treatment of psychotic disorders through an interdisciplinary treatment team seeking to bring multiple perspectives and understandings to the task of treatment. Throughout the integrative treatment effort at Riggs there is attention to three crucial factors: (1) respect for the patient’s authority in the treatment, viewing him or her as an active and responsible agent, including selection of only those patients with psychotic disorders for whom this is a reasonable assumption; (2) attention to the importance of evolving and ongoing relationships as a central component of treatment; and (3) a commitment to the uncovering of the meaning of symptoms and of treatment resistance itself.

Meeting twice each week, the treatment team is headed by a team leader and consists of psychotherapists, social workers with family therapy credentials, psychopharmacologists, nurses, substance abuse counselors, and representatives from the Therapeutic Community Program (Krikorian & Fowler, 2008; Shapiro & Plakun, in press). The psychotherapist is in charge of holding all aspects of the patient’s care in mind and offering a dynamic formulation to the team to help make sense of our work together. The treatment plan often includes psychodynamic psychopharmacology as described by Mintz and Belnap (2006), where meaning effects of medication are articulated. The importance of the Therapeutic Community as a locus for social engagement, feedback about behavior, personal responsibility, and patient authority are all intensively applied in an effort to help patients discover their competence and to encourage independent functioning and adaptation to the demands of independent living. This facet of the treatment program meets the intent of the PORT recommendations for vocational rehabilitation as patients pursue various work and leadership opportunities within the treatment program.

Since nearly half the patients diagnosed with schizophrenia will have a comorbid substance use disorder (APA, 2004), our treatment approach provides both individual and group substance abuse counseling with a substance abuse staff member on each treatment team. Finally, under-
standing the family system of the patient and the interaction effects of the patient with schizophrenia and the family system are an important component of the treatment team formulation (Schwartz, 2007).

Conflicts within the field get played out within the team dynamics, as do conflicts between the patient and the family (Krikorian & Fowler, 2008). When all goes well, the team can get hold of the various conflicts and work to be a representative of a coherent Third (Muller, 2007) to the treatment dyads. Obviously, this does not always go smoothly. Treating these patients over a long period of time through intense engagement produces powerful staff disagreements, anger, withdrawal, splitting, and other strains staff must contend with and understand in order to work effectively with our patients and their families. These strains are multiplied by our pursuit of psychodynamic treatment in a larger professional culture that often does not recognize the efficacy of an intensive approach going beyond the intent to manage and control patients' symptoms, but invites patient authority in a collaborative treatment effort. Staff members carry the tension within themselves and within the group as we pursue a complex way of working with disturbed and disturbing patients and their families.

In the following section I provide a clinical report illustrating the complex psychodynamic dilemmas encountered when treating psychotic spectrum disorders. The patient presented with intermittent mood incongruent psychotic episodes that could be clearly linked to developmental transitions in his life, demonstrating a stress-diathesis dynamic. Other likely contributing factors to developing a psychotic disorder included a family history of severe mental illness, and his father’s immigration to this country as a young man. The patient had a history of good inter episode recovery and was able to work with the treatment team and in his psychotherapy to develop a more complex understanding of how his conflicts and defenses were manifest in his psychotic episodes.

CLINICAL ILLUSTRATION*

Mark was a married man in his 30s at the time of his admission to Riggs. He experienced his first psychotic episode after leaving home to attend college in a different area of the country. While there he experienced the traumatic death of a peer in a freak accident in the dormitory.

*Personal details have been changed to protect the identity of the client.
Mark unraveled within weeks of this death and remained in bed for a week—mute, staring with his mouth open, as if catatonic except for making odd gestures with his hands. His roommate called his family, who came to the school and had Mark hospitalized. At the moment of separation from his family in the emergency room he became violent, assaulting staff, eventually winding up in 4-point restraints and sedated. Mark remained delusional and paranoid during his hospitalization, was diagnosed with a psychotic disorder treated with an antipsychotic and a mood stabilizer. Returning home to live with his parents, Mark completed his degree in engineering at a nearby college.

The family history indicated that Mark’s father immigrated to the United States from Belgium at age 25. Mark stated that although he had felt close to his father, there had also been a deep mystery about his father, who never talked about his childhood in Belgium or his family history. Mark’s mother’s family included the patient’s great grandfather, who was described as a “failed genius,” living out his last years psychotic and in a state hospital. Two cousins on the maternal side had mental illness, one a schizoaffective disorder and one a bipolar disorder. Mark had three older siblings, one of whom carried a diagnosis of bipolar disorder.

Mark worked successfully as an engineer after college in a relatively low stress business. His father became ill several years later and died of cancer. Mark was with the family for this important event, describing his father’s condition at the end of his life as “gruesome.” Several months later Mark had another psychotic episode in which he tried to kill himself with carbon monoxide poisoning, but narrowly survived. He had delusions that he was riddled with cancer, that he was losing his vision, and that he was never going to be able to succeed in the world, maintaining a persistent fantasy that he was now a lost boy. Once again he recovered with the introduction of antipsychotic medication and supportive, once-per-week psychotherapy lasting 18 months. Mark married a woman and started his own surveying company, achieving financial independence from his family, and developing a solid client base. He and his wife both described the early years of the marriage, before the birth of their first child, as “wonderful.”

Upon the birth of his first child Mark once again fell apart. His wife was in a motor vehicle accident two weeks after the birth of their daughter and almost bled to death from injuries. Mark was tormented and could not bear the idea of the close call with death his wife had endured so shortly after giving birth. During her convalescence and the period of maternal preoccupation with their new child he felt he had lost his wife as his own primary maternal support. Mark attempted suicide in his despair, but was discharged from the emergency room following
this attempt. At home he became progressively prone to rageful behavior and then regressed to the point of experiencing himself as an infant, insisting on maternal care from his wife. Mark feared that if left alone he would either kill his daughter or himself. He was unable to work, and imagined that he had a brain tumor or some other lethal illness that would kill him. After six weeks of progressive deterioration, including delusions, regressed behavior, and "rage attacks" in which he feared both destroying others and being destroyed by them, his physician placed Mark on two antipsychotics, a mood stabilizer, an antidepressant, and a benzodiazepine that seemed to abate his positive symptoms of affective dysregulation and paranoia. However, negative psychotic symptoms emerged, with Mark showing little interest in his daughter, his wife, or independent adult functioning. After another 8 months of unremitting lethargy and negative symptoms treated with various medication trials, his outpatient psychiatrist recommended ECT, which terrified Mark. He refused this recommendation and after several more weeks his wife gave him an ultimatum: he could agree to ECT or seek long-term residential treatment. Reluctantly, Mark agreed to come to the Austen Riggs Center.

At the time of admission to Riggs Mark had negative symptoms, with marked psychomotor slowing, thought blocking and a flat affect, as well as appearing overmedicated. He did not have prominent positive symptoms, although delusions and confusion were noted in the months prior to admission. Mark complained of being confused and disoriented. Psychological testing and the clinical history were consistent with the diagnosis of a psychotic illness, most likely a schizoaffective disorder. Interestingly, he was eager to engage in four-times-a-week psychodynamic therapy, felt deeply understood and rapidly developed an idealizing transference. In an early session, out of a thick mental haze and with great effort, Mark spontaneously reported an early memory of being 4 years old in nursery school, where he developed such a yearning to be home with his mother that he left the school, running down the sidewalk in the snow until a motorist stopped to pick him up and returned him to the school. He said he had felt in an absolute panic about separation from his family and that this feeling of panic about abandonment often led him to feel he was losing his mind and falling into a million little pieces that could never be retrieved.

In the context of the stable holding environment of the milieu, nursing support, and psychotherapy, Mark began to speak about his catastrophic fears about the end of the world, and how these underlying fears became exacerbated with the birth of his daughter. Gradually he was able to think about the dynamic conflicts underlying his acute and recurrent decompensations: his fear of annihilation; conflicts surround-
ing his hostile dependence on his mother and on his wife, and how coercive he could become if he felt dropped by them; his deep attachment to his father, who he felt had sustained him through a painfully shy and awkward childhood; his cherished position as the youngest child in his family, that he was angry about losing by growing up; and his lifelong difficulty meeting developmental milestones without major psychic disruption. Mark observed that he had never been able to construct a “big picture” narrative of his experience.

Family meetings with his wife and toddler daughter also became an important part of the treatment. His wife was annoyed that Mark had abandoned his business while insisting that she go back to work full-time to financially support the family. Mark had competitive and aggressive longings to be the center of his wife’s world, insisting that she provide equally intensive care for their daughter and for him. His wife was able to confront Mark about his “rages” soon after the birth of their daughter, and about how frightened she had become of him. The couple worked hard to reconcile the events of the past 18 months and to come to some understanding about each of their family of origin dynamics that were played out in the marriage. Contrary to the PORT recommendations, examining the intergenerational family dynamics of both members of the couple gave them each a greater appreciation for the conflicts each brought to the marriage, how these had been unconsciously lived out within the marriage, and how they contributed to the angry impasse they experienced with Mark’s most recent decompensation.

Mark arrived at Riggs on daily medications, as follows: lithium carbonate 1200 mg, risperidone 4 mg, aripiprazole 30 mg, venlafaxine 150 mg, and clonazepam up to 6 mg (as needed medication). His psychopharmacologist worked with Mark to understand how he might be using such a medication regimen to dull his mind and his experience. Mark agreed, but felt that this was an effort to “keep the peace” at home by avoiding intense affect states he could neither understand nor contain. He was also desperately averse to the recommendation of his outpatient psychiatrist for ECT and hoped that if he took enough medication he could live out his days in a stupor without further confrontation. Over time his medication regimen changed. Risperidone was discontinued and clonazepam decreased to 3 mg daily in divided doses. Lithium carbonate was decreased to 900 mg daily. After presentation and consultation with a team of psychopharmacologists, methylphenidate 20 mg daily was added. Venlafaxine remained at 150 mg and aripiprazole at 30 mg. As with most of our patients, one aim of psychopharmacological treatment is to allow the patient to engage as productively as possible in therapy and the milieu, preserving a space for affective expression.
that is not suppressed by medication. Often this involves addressing
the patient’s defensive overuse of medication to avoid painful, but
manageable, affective states (Mintz & Belnap, 2006).

Within the transference, Mark found the focused attention of his
psychotherapist intensely gratifying and took the stance of an overly
solicitous and compliant patient. Although a therapeutic regression
within the transference is the expectable course of an intensive psychody-
namic treatment, a paradox in Mark’s case was his defensive use of
the gratifying aspects of the therapeutic situation to reconstitute higher
ego functioning within several months. In some respects he was eager
to please the therapist to show her what a “good boy” he was, evoking
his therapist’s concern this was a flight into health, an issue that was
engaged in the therapy in some depth.

Slowly, Mark grieved the losses in his life incurred through normal
developmental milestones and separations, and also the deeply traum-
atic losses he had experienced. Feelings of being inferior to his own
idealized father surfaced. He shamefully admitted that he felt he could
never be as competent a father to his daughter as his own father had
been to him. Mark used the shelter of the hospital and the support of
the positive transference to begin the grieving process. He grieved more
fully his experience of having nearly lost his wife in the car accident,
and his anger that, though she survived this medical crisis, he again
lost her through her necessary interest in and care of their infant daugh-
ter. Mark felt his mind was coming apart as he watched the maternal
care he was accustomed to receiving being redirected toward his young
daughter. His guilt about murderous aggression toward his family and
toward himself was gradually articulated. He came to understand the
way his wish for maternal care and delusional insistence on being the
true infant in the household were defensive solutions to his dread of
being the large and potentially aggressive man he might be.

While at Riggs, Mark worked with our woodworking instructor to
construct a toy chest for his daughter. He used the freedom of the open
setting to find ways of being alone and on his own for periods of time,
developing an enjoyment of quiet time spent in the greenhouse. In these
endeavors Mark regained a sense of mastery and also took small steps
toward claiming himself as the father of his child and as a competent
member of the adult community.

Mark left Riggs after 5 months. He was discharged on Lithium 900
mg, methylphenidate 20 mg, venlafaxine 150 mg, and aripiprazole 30
mg. He began four-times-weekly psychodynamic treatment with a
therapist in his hometown. At a two-year follow-up he was reported
to be doing well, having restarted his business and rebuilding his cli-
entele. There had been no further psychotic episodes and he remained
stable on his medication regimen and in his psychotherapy. Continuing couples therapy helped repair the damage he had done to his marriage, while allowing the couple to work out their parenting conflicts and improve their communication skills.

DISCUSSION

Working in a psychoanalytically oriented hospital with profoundly ill individuals, many of whom arrive at Riggs following the failure of all of the various treatments general psychiatry has to offer, presents unique challenges. Mark’s prior treatments had consisted of multiple hospitalizations, multiple drug trials, and 18 months of once-weekly cognitive behavioral therapy focused on symptom management and the development of coping skills. Following the failure of these standard interventions, Mark might be thought of as “treatment resistant.” Coming to Riggs offered a treatment that allowed him, for the first time, to think about his developmental history and his family history. Over time he was able to construct a coherent meaning to his symptoms and appreciate with great sadness the pain he had endured with each and every separation in his life, beginning in early childhood. Instead of a person with a catalogue of psychiatric symptoms to be managed exclusively through concrete, “evidence-based” interventions, Mark gradually became a man with a life narrative he could reflect upon. This process was ego-strengthening for Mark, who once given the opportunity, had an excellent ability to begin to “connect the dots” of his life.

In many ways, Mark’s story is a hopeful one. Some patients with psychotic disorders are not candidates for an open setting or for the assumption they can be considered competent adult human beings. Many of our patients with psychotic disorders do not possess such ready ability for engagement or insight. Mark’s conscious interpersonal hunger and his clarity about that place him at the upper end of the psychotic spectrum. Other patients at Riggs suffer from more difficult psychotic disorders. They do not always have a history of occupational success, meaningful sustained relationships, or cognitive capacities for insight into their illness and its antecedents. The treatment of these more profoundly ill patients requires time and patience, while utilizing all the humane modalities we can bring to bear.

The despair of both the patient and family are prominent in situations where the pathology and course of the illness are not quickly responsive to treatment. Sometimes the focus of treatment is helping a patient and family come to grips with rage and grief related to profound limi-
tations and deficits in a patient, while helping a family accept the child they have rather than the one they might wish for. Nevertheless, there are clear instances where even the most seriously disturbed individual, out of the mainstream of life and functioning marginally for years, can gradually achieve independent functioning with intensive treatment, including a resource rich environment of community engagement, vocational opportunity, an expectation of personal responsibility, and a respectful stance that each person has their own story to tell about the meaning of their lives both before and after their psychotic disorder emerged. It is this latter opportunity that is often lost in our contemporary culture; a careful psychotherapeutic treatment that invites the patient to bring his or her deepest concerns, hate, love, and confusion into a relationship where steadfast curiosity keeps the possibility of new discovery and change open for the patient. In this model the therapist engages the patient in an interest in the internal world while keeping an attentive eye on the task of ego adaptation to the demands of reality.

While the PORT recommendations about treatment seem piecemeal and additive in nature, the treatment at Riggs seeks to apply “best practices” in an integrative, need-adapted fashion. Our aim is to help our patients develop the capacity for a well-lived life as full citizens of the community with the attendant rights and responsibilities of such citizenship. Given the dreadful history of the inhumane and misguided treatment of psychotic disorders, our first priority is to do no harm, respecting the vast complexity of mind, culture, and biology in our approach without becoming narrow or reductionistic in our thinking or our treatment.

When faced with the choice of ECT or residential treatment, Mark was able to use his own authority to opt for treatment in the open setting and the responsibilities that entails. He was interested in and able to use psychodynamic therapy to enlarge his understanding of the timing and the meaning of his most recent psychotic episode, and was able to link his previous episodes to periods of stress around developmental transitions. He was able to use the network of supportive relationships available to him to create a safe enough environment to do this work. Finally, Mark was devoted to working to preserve his marriage and to develop his paternal relationship with his young daughter. He was able to use all aspects of the Riggs approach and the open setting to begin developing his capacity for psychological insight and a return to family and occupational functioning.
REFERENCES


The Austen Riggs Center
25 Main Street
Stockbridge, MA 01262
jane.tillman@austenriggs.net