THE USE OF SOME LEARNING THEORY DERIVED TECHNIQUES IN THE TREATMENT OF A CASE OF PARANOID SCHIZOPHRENIA

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In the last ten years there has accumulated a growing body of information concerning the use of learning theory to increase the efficiency of psychotherapeutic procedures (for example reviews by Eysenck, 1960; Wolpe, 1958). Much of this published literature concerns neurotics and has been concerned with monosymptomatic reactions like phobias, etc. Such techniques have generally yielded very favorable results (Wolpe, Salter and Reyne 1964). The literature on such procedures with psychotics is much more sparse. Survey of the literature indicates that operant conditioning appears to be the procedure of choice in the treatment of psychotics. The primary goals in the treatment of the psychotic patient appear to be much more limited in scope and confined largely to inducing the psychotic patient to participate more fully in his immediate environment and reducing the extent to which he is a management problem (Ayllon 1960, King et al., 1960). In contrast, the purpose of this paper is to describe the treatment of a case of paranoid schizophrenia in which the primary therapeutic goal was social rehabilitation. The direct and intentional manipulation of this patient's behavior constituted the core of therapy. Behaviors that the therapist considered appropriate were clearly and explicitly stated to the patient.

Background Information and Problem Areas

The patient is a 39-year-old, white, married female admitted to our hospital for the first time on an involuntary basis. Prior to her present hospitalization this patient had five psychotic breaks within the space of four years. Even though there was some remission of gross psychotic symptoms between psychotic breaks, the patient was never able to function adequately and independently and care for her basic responsibilities as a wife and mother during these intervals. In short, she was unable to return to that pattern of life she had enjoyed prior to her first psychotic break and was continuously in therapy on an out-patient basis between hospitalizations. It was only when she became completely unmanageable at home that her psychiatrist recommended hospitalization. On these previous hospitalizations she was treated with E.C.T., chemotherapy and analytic psychotherapy in private sanitariums. The patient was also receiving psychotherapy from a psychiatrist on an out-patient basis prior to her present psychotic break. The patient has a B.S. degree and is an ex-school teacher. She has been married many years and quit teaching when she became pregnant. On admission the patient was having auditory hallucinations and was markedly delusional in a persecutory sense. Her principal problems in living were: (1) she felt she was being accused of making improper sexual responses towards her six year old son. (2) The patient felt she was being accused of making sexual responses towards other females and she was unable to use the ward's shower together with other female patients. (3) The patient had failed to learn to relate to her child within a realistic frame of reference. She was inclined to vacillate in her attitude towards him between over indulgence and complete indifference. These behaviors stimulated disharmony in the home and alienated her husband. (4) The patient has always been resistant to sexual intercourse when it was initiated by her husband. (5) The lack of
communication between husband and wife and
the former's withdrawal and absorption in his
hobbies. (6) The patient's belief that her pre-
vious psychiatrist and her sister-in-law were
spying on her in her present hospital location.

Systematic Model Used

In treating this patient the basic theoretical model
used was the following. The patient was seen as re-
sponding non-adaptively at the mediating (verbal),
autonomic and motor levels. Traditional psycho-
therapy assumes that changes induced at the mediating
level (thinking and talking) will generalize to the au-
tonomic and motor levels. Both clinical evidence and
recent experimental evidence suggests that such gen-
eralization does not invariably occur. Experimental ev-
dence indicating that the verbal, somatic and motor
sectors of behavior correlate poorly comes from the
work of Lazovik and Lang (1963), and Cowden and
Reynolds (1961). The patient's behavior pathology
was conceptualized broadly in terms of Hull's "habit
family hierarchy." Because anxiety had become at-
tracted to the more responsive, the patient had now
regressed to less socially adaptive undifferentiated
responses of a polymorphous perverse nature (sexual
responses towards children, homosexual responses,
etc.) lower in the habit family hierarchy. The persis-
tence of these behaviors may, to a degree be explained
by the tendency of the patient's prior therapists to
respond verbally to them, hence reinforcing them and
providing the patient with a channel of communica-
tion with her social environment, however primitive
and undifferentiated it was. The patient's problems in
living were conceptualized in terms of basic principles
of learning. The method used was a learning theory
rationally oriented behavior therapy which consisted
largely of desensitization, acquisition of more adap-
tive responses, counter-conditioning, externalization,
clarification, labeling and discrimination of feelings. In
the earlier stages of therapy the patient's delusional
elaborations per se, were largely ignored, and so was
her tendency to speak almost exclusively about sex in
a very self-consciously anxious way. Whereas the pa-

tient remained verbally responsive when elaborating
on sexual material, she began to block noticeably and
become increasingly resistant when she was asked to
describe in specific and concrete ways communica-
tional relationships between her husband, herself, and her
son. (For example, she complained of a short atten-
tion span, that the therapist had no understanding of
children, and that she was feeling tired, etc., etc.) This
resistance was immediately interpreted and worked
through utilizing a number of specific instances and
incidents the patient produced. (It was felt that some
psychoanalytic methods like "interpretation" and
"working through" do have limited utility in modify-
ing the patient's verbal behavior.)

Broad Targets of Therapy

The primary targets in therapy were 1) to teach
the patient to think more clearly about her problems
by helping her to more appropriately label her experi-
ences, discriminate between them and to more ac-
curately grasp relationships between them and 2) to
induce the patient to engage in more adaptive motor
behavior in relationship to her husband and son. The
third goal of therapy was to reanimate the patient
previously acquired vocational and social skills (which
had fallen into disuse) which were likely to elicit posi-
tive reinforcement from her social environment and to
strengthen her sense of relatedness to it.

Early in therapy the therapist decided that he
would react consistently to only two primary problem
areas. The first one was the patient's fear of attacking
her child sexually. The second was the patient's ten-
dency to reinforce her husband's withdrawal from her
by overindulging her child and by generally reacting
to him on the basis of inaccurate discriminations. The
duration of therapy was six weeks and the patient
was seen for one hour and twenty minutes on a daily
basis. The therapeutic procedures were to a consider-
able extent applied to both problem areas concomi-
tantly.

Techniques Used to Correct
Problems with Child

The principles of learning outlined above were
related to the patient's first major problem in the fol-
lowing manner. An effort was made to extinguish her socially non-adaptive
mediating responses (her mental and verbal
preoccupation with hurting her son). It was
felt that inappropriate stimulus generalization
was probably responsible initially for the ac-
quisition of these verbal and mental preoccu-
pations. But anxiety reduction may have been
involved in the maintenance of these re-
sponses. It was felt that the child's physical
presence was anxiety provoking to her partly
due to her inability to manipulate the child
effectively and her intense awareness of social
expectations in this regard. These mediating
avoidance or escape responses were non-adap-
tive, because in the long run they generated
more anxiety and because they interfered with
her ability to experiment with and acquire
more adaptive techniques of coping with the child.

The first task was to reduce the anxiety as-
associated with her sexual apprehensions about
hurting the child. This was accomplished by a
modified form of counterconditioning and
desensitization. A specific block of therapeutic
time was assigned to verbally eliciting from
the patient her positive feelings towards her
child.

Specifically she was told to recall and ver-
balize five specific positive incidents in rela-
tion to her child and while she was con-
cluding, the therapist deliberately recalled her fear of hurting the child sexually and requested her to verbalize it. This technique was used two to three times in each therapy session. This technique was terminated after the tenth therapy session. In addition to this verbal technique the child's weekly visits to the hospital were also used for desensitization of the patient’s motor and autonomic behavior and the acquisition of simple play skills.

In the initial stages of therapy the patient was required to spend a specific block of time (twenty-five to thirty minutes) responding only to the child, but in her husband's presence. The patient was clearly and explicitly told what games to play at these times and in general these games evolved along a physical contact continuum. (For example the initial sessions were devoted to simply playing ball with the child. Later more meaningful participant skills, like putting puzzles together and making block designs were used. Towards the termination of therapy physical contact games, like blind man's bluff, swinging and playing “doctor” were used.)

As the therapy progressed this procedure continued, only now the patient was required to play with the child further and further away from her husband. At the end of therapy she was alone with him and outside her husband’s sphere of observation. In the initial stages of this procedure the patient was somewhat resistant and anxious about the procedure but towards the end of therapy her anxiety had tapered off to the point that it was practically nil and she was able to play comfortably and relaxedly with the child alone and away from her husband.

In addition to the above techniques, towards the termination of therapy (the last week) the patient's recollection that when she was six years old she was molested in a field by two boys, was indicated to bear a certain gross similarity to her present relationship to her child. The therapist then elicited from the patient the specific and concrete differences between these grossly similar experiences and she was required to list them in a record book. It was then pointed out to her that her fear about her sexual feeling towards her child was partly a function of stimulus generalization (the principle was explained to the patient).

In summary, this specific symptom yielded when attacked at the motor level (induced approach behaviors) and the mediating level (contiguous eliciting of positive and negative feelings from the patient plus improving the patient's discriminative ability when thinking about this problem).

TECHNIQUES USED TO CORRECT PROBLEMS WITH HUSBAND

In the case of the second problem area, the patient's relationship to her husband, the following strategy was employed. The patient recalled that her first heterosexual experience was with a man who forced intercourse on her. She reported that she had prior to this incident felt very warmly towards him and that he had promised to marry her. But after this sexual incident she never saw him again and later discovered that he was already married in a different state.

The patient's resistance to sexual relationships when initiated by her husband was in a matter-of-fact but clear manner pointed out to be similar in some respects to her initial experience of heterosexual intercourse.

The therapist then elicited verbally from the patient the gross similarities between the initial experience of heterosexual intercourse and her present attitude towards sexual behavior when it was initiated by her husband. At the same time the marked differences between the two experiences were clearly and specifically elicited from the patient and she was required to itemize them in a record book. The patient was able to recognize that to some degree her present reactions to her husband's sexual advances are related to the early episode in which she acquired negative feelings toward sexual responses initiated by males. She was able to see that she was reacting the way she was, partly due to the gross similarities and poor discriminations made between these experiences.

It was further pointed out to the patient that her premorbid tendency to overindulge her child and to attend to him to the almost complete exclusion of her husband was reinforcing her husband's withdrawal from her and his growing preoccupation with his hobbies. (The patient reports that her husband after he has returned home from work and eaten his meals}
The patient's behavior in this realm was modified through the following strategy. On each visit (one a week) of the patient's husband to this hospital the patient was required to spend a separate block of time (twenty-five to thirty minutes) alone with her husband. She was required at this time to talk to him only about present concerns and future plans and her husband was similarly instructed. It must be noted that when the patient's husband visited her (on the average once a week) he brought along their son and his (husband's) mother. When the patient was granted an "off-grounds pass," she had previously been inclined to get in the front seat of the car with her husband and put the child between them. The therapist now required the patient to sit alone in the front seat with her husband and insisted that the child remain in the back seat with her mother-in-law. The intention here being to give her husband a better opportunity to relate to his wife without the continuous interference and demands that the child was making upon her.

During her stay in this hospital (and when she was in therapy) this patient had four "home visits." On all of these visits the therapist specifically indicated where this time should be spent and with whom. The patient and her husband were required to go to a local forest preserve where there were cabins for couples. It was felt that every effort should be made to ensure that the patient's copulatory responses would occur in an environment as completely unlike her home as possible; because it was felt that negative feelings had become attached to environmental cues in her home and that these cues would retard the establishment of an optimally satisfying heterosexual relationship. Because the patient was hospitalized she was of necessity on a heterosexual deprivation schedule and this fact, it was felt, would facilitate reactivating the more adaptive heterosexual responses. The patient's husband was quite responsive to this plan and the patient spent four weekends alone with her husband. It was noted that as a function of better communication between husband and wife and a more satisfying sexual relationship with him, the patient became less preoccupied with the possibility of homosexual behavior on her part and in fact homosexual material almost completely dropped out of her verbal behavior in therapy and she was able to shower comfortably on the ward with other females.

Since the patient was a college graduate and had prior teaching experience she was required to participate in an ongoing program in which she functioned as a teacher three times a week for two hours teaching other hospital patients basic skills like arithmetic, reading, etc. During the patient's stay in this hospital there were two social events in which hospital patients played host to visitors from the local community. On both these occasions the patient played a prominent part and arrangements were made to have a number of professional people go up to her and tell her how well she was looking and doing.

OUTCOME

At the termination of therapy all delusional matter had dropped out of her speech, her home visits were reported to be extremely satisfactory and the reports from ward attendants, patient's relatives, and those who supervised her recreational and industrial activities on the hospital grounds were all positive. At this time the patient was discharged from therapy and it was recommended that she be discharged from the hospital.

A follow up questionnaire sent one year and four months later to the patient and her husband, indicate that there has been no reactivation of "symptoms" and that the patient has received no in or out-patient psychiatric treatment of any sort (chemotherapy, psychotherapy, etc.) since discharge from the hospital. Further there is no discernible evidence of "symptom substitution" and in fact the patient has begun teaching both young and older children in her community school system. The patient reports that her relationship to her son and husband is "good," but her husband rates her as "excellent" in both the above areas.

CONCLUSION

Traditional therapy attempts to change behavior (emotions and acts) indirectly, through changes induced in the mediating system (verbal and language behavior). In the
above case therapy was not confined to the mediating system. A direct attack was made of the pathological behavior itself. It is the primary hypothesis of this paper that changes in the mediating responses and in feelings are most effectively induced by first changing the motor responses themselves.

REFERENCES


