

## **An Integrated Approach to the Treatment of Schizophrenia With Medications and Psychotherapy, The Chestnut Lodge Experience**

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A symposium was held in New York City in 1980, entitled "The Interrelationship of Psychotherapy and Psychopharmacology." At that meeting, Dr. Otto Will reflected on the many and diverse treatments for schizophrenia with which he has had contact during his long career in treating this illness.<sup>1</sup> He listed eighteen treatments, ranging from "an attitude of nihilism, reflecting the idea that the organism is biologically inadequate...and will likely be made worse by any form of intervention," to "the intrathecal injection of horse serum with the purpose of producing a sterile meningismus," to "the intravenous injection of gold salts..." and on to our most current methods including psychotherapy and medications. We modern readers exclaim with horror: "Horse serum?!...gold salts?!" We shiver at our predecessors ignorance and naiveté, inwardly smiling with amusement and congratulating ourselves on how far we have come in our scientific knowledge and sophistication. But before our smugness gets the best of us, let us realize that a psychiatrist fifty or even twenty years from now may chuckle or recoil with incredulity at a similar list of our current treatment methods for schizophrenia. I would encourage all of us, as we struggle with the complex and difficult issues raised here this weekend to maintain an attitude of appropriate modesty. Tom McGlashan, my colleague at Chestnut Lodge put it well when he wrote: "The 'truths' about schizophrenia unfortunately lie strewn within a minefield of extreme expectations that can destroy the careful reconnoitering of reason. One of those destructive expectations,...takes the form of an all-or-nothing cry for a single, clear and definitive *answer*. Such are the wishes engendered by this maddening and persistent enigma labeled schizophrenia. We propose that the first step to unraveling this enigma, however, lies in recognizing this wish and calling its bluff."<sup>2</sup>

It is in this spirit that I wish to address the topic of the combined treatment of schizophrenia with psychotherapy and psychopharmacology. I do not propose to offer a prescription or an answer to the problem. Instead I wish to examine a particular approach to the illness with which I have had experience and which I feel is comprehensive and useful. I will broaden the purview of my discussion to include reference to other psychosocial interventions besides psychotherapy. After briefly reviewing some of the literature on the topic, I will describe in detail the current model of multidisciplinary treatment of schizophrenia employed at Chestnut Lodge. I will then attempt to trace the development of this treatment paradigm over the years of Chestnut Lodge's existence, with special attention to the hospital's experience with the psychotherapy of schizophrenia with and without concurrent use of medications. I then offer some personal reflections based on my experience at Chestnut Lodge as both a psychotherapist and ward administrator.

An exhaustive review of the literature is beyond the scope of this paper, but I would like

to highlight some of the important studies that have been done in this area. While there is no shortage of literature on either the psychotherapy of schizophrenia or the drug treatment of the disorder, there has been surprisingly little written specifically addressing the combined treatment with therapy and drugs. Given the fact that in practice, most clinicians probably treat their schizophrenic patients with exactly this combination of approaches, it is a subject which begs for more attention. Most of the papers that I was able to locate in the English-language literature considered the outcome of schizophrenic patients treated with one medication regimen or another or one form of psychotherapy or another. What did not seem to be addressed was the particular effect that antipsychotic and other medications have on the various dimensions of the psychotherapy of schizophrenia, such as transference and countertransference, quality of relatedness and engagement, the therapeutic alliance, freedom of expression of affects, ability to process interpretive interventions and the development and depth of insight. I will come back to this later, but first let's continue with an overview of the literature.

Mortimer Ostow was one of the first psychoanalysts to write about combining psychoanalysis and psychotherapy with drug treatment. In a book called Drugs in Psychotherapy and Psychoanalysis,<sup>3</sup> published in 1962, he describes in detail the treatment of a paranoid schizophrenic patient in this manner. Between 1967 and 1981 there were a number of studies which attempted to evaluate the effectiveness of individual psychotherapy for schizophrenia. These included the studies by May<sup>4</sup>, at Camarillo State Hospital in California, Grinspoon, Ewalt and Shader,<sup>5</sup> at the Massachusetts Mental Health Center, Karon and his group in Michigan between 1969 and 1981<sup>6 7 8 9</sup> and Rogers<sup>10</sup> in Wisconsin. It would take many hours to discuss these research studies in any detail, but suffice it to say that with the exception of the Karon study, none of the findings in any of them permitted an enthusiastic endorsement of individual psychotherapy for schizophrenic patients. All of these studies have been criticized for various methodological shortcomings, but nevertheless, collectively they did influence the attitude of the profession towards the psychotherapy of schizophrenia. Stanton and his group<sup>11</sup> in Boston reflected that these studies "changed the question from whether it was ethical to withhold psychotherapy from a schizophrenic patient... to a new ethical question--whether it was appropriate to give psychotherapy when its value had not been demonstrated." In an attempt to address these problems, this group<sup>11 12</sup>, conducted an elaborate study comparing two forms of psychotherapy for schizophrenia, what they call "exploratory, insight-oriented" and "reality-adaptive, supportive" therapies. They found that the insight-oriented therapy was preferentially effective in the areas of ego functioning and cognition and the supportive therapy exerted preferential effects in the areas of recidivism and role performance. They noted, however, that overall, the magnitude of the differences was low.

In a paper written in 1983, McGlashan<sup>13</sup> presents an exhaustive review of the literature on intensive individual psychotherapy of schizophrenia. There, he states that "most latter-day psychotherapists, with exceptions, do not denounce the use of psychotropic medication. Drugs are advocated for reducing anxiety, regression and cognitive disorganization to render the patient more accessible to interpersonal contact. They are often viewed with reserve, however, *as potentially capable of blunting affective availability in a manner antitherapeutic to the investigative endeavor.*" (my italics) Dr. David Feinsilver, my colleague at the Lodge has made some interesting attempts<sup>14 15 16</sup> to present an integrated approach to treatment, using concepts

proposed by the late Ping-Nie Pao (formerly the director of psychotherapy at Chestnut Lodge), his own clinical experiences and a number of other theoretical perspectives. Dr. Feinsilver's book has recently been translated into Italian by Dr. Giovanni Foresti and colleagues.

It is hard to know how one should put together all this research data, with all its elaborate design, implementation and statistical manipulation. We could adopt Gerald Klerman's pessimistic position and conclude, as he does,<sup>17</sup> that "the evidence...would indicate that no further research on the intensive individual psychotherapy of schizophrenics based on psychodynamic or interpersonal principles is warranted." I, for one, refuse to throw in the towel so quickly and I bristle at such a statement, which would delegate the psychotherapy of schizophrenia to the junkyard of anachronisms. To the contrary, I think the evidence available to date is far from clear or conclusive. And as I noted before, the literature on the combined treatment of schizophrenia with medications and psychotherapy is inadequate to say the least, and I believe it is premature to make such judgments. Another crucial point, and one that Klerman does not acknowledge, is this: when we talk about the treatment of schizophrenia it is unwise if not impossible to restrict our attention solely to individual psychotherapy, whether or not it is combined with medications. Chestnut Lodge has learned this lesson all too well over many years of experience. The evidence is clear, it seems to me, that in any discussion of the treatment of this devastating illness, one must speak in terms of a multimodal and multidisciplinary approach. Individual psychotherapy must be seen as only one piece, and in most cases probably a central piece, in such a broad program of treatment. I very much like John Fort's<sup>18</sup> analogy of the arch to describe the treatment of the schizophrenic. The foundation of the arch can be thought of as equivalent to the patient's own ego and the milieu in which he finds himself. Piers are erected, which in this analogy would be the use of psychotropic drugs on one side and steady, consistent relationships on the other. The side stones or voussoirs have to be carefully chiseled and may represent many forms of treatment such as family therapy, vocational therapy, or rehabilitative efforts. The arch would collapse without the keystone, a large but variably sized block which locks all the other parts into place, and which must be sculpted to conform to the hoped-for characteristics of the individual psychotherapist. Dr. Fort lists some of these characteristics, which he believes should include at least the following: an interest in the disease, therapeutic zeal, persistence and patience, a capacity for drama and projection of the self, a capacity for sadism, empathy and imagination, and a lack of arbitrary dogmatism,

I would like to move on at this point to describe the multidisciplinary, multimodal treatment program currently employed at Chestnut Lodge Hospital. A word about the hospital is in order here for those of you not familiar with it. The Lodge is a small private psychiatric hospital located approximately fifteen miles outside Washington DC, in the suburbs of Maryland. The campus is over one hundred acres, and there are about fifteen buildings on the grounds which include patient units, offices, a dining room, a high school for adolescent patients, and various recreational facilities. There are approximately ninety adult inpatients and thirty adolescent inpatients as well as forty or so day treatment or partial hospitalization patients. The medical staff is composed of about thirty-five clinicians, mostly psychiatrists, although there are several psychologists on staff as well. I have a few slides of the grounds of the hospital to give you a feel for the setting. (slide 1) This the original hospital building which was a country inn until 1910, when it was converted into a psychiatric hospital. The next slide (#2) is the view

as one drives onto the hospital grounds. The next three slides (# 3,4,5) show the large courtyard surrounded by the four main adult units, which were completed and occupied in September of 1989. I have particular fondness for the next building, (slide 6), called "Office wing B," which houses my office. There are four other psychiatrists in the building with me. Other doctors have offices in various locations on the grounds. This (slide 7) is a general view of the grounds, with the research institute in the distance. Finally (slide 8,9), two shots of the adolescent division of the hospital has four units like these, housing about thirty inpatients.

It is important to understand the nature of our patient population in order to put our treatment program in perspective. Traditionally, the hospital has been known for its expertise in the management of so called "treatment-resistant" or refractory patients, that is, those patients for whom a variety of relatively short term treatment approaches have failed or have been incompletely effective. We see a group of schizophrenic patients who are in the most severely ill category and who are more or less chronic by the time we meet them. In other words, many or most of our schizophrenic patients would fall into the bottom third prognostic group as originally described by Kraepelin; that is, one-third improve, one-third stay about the same and one-third have a relatively relentless deteriorating course.

In order to get an overview of the Chestnut Lodge program, let us follow a hypothetical schizophrenic patient through its various component parts. [slide10:flow chart] We are talking now about an "ideal," successful patient for the purpose of explication. Obviously, not all patients are successful and not all patients move in such an organized or stepwise fashion through the system.

Upon his arrival at the hospital, the patient is admitted to one of three locked inpatient units, the Meyer House, the White House or the Sullivan House. These units, which were opened about a year ago, are called houses because they were purposely built to simulate the look and feel of a home rather than an institution, as you could see in the slides I showed earlier. The units differ somewhat in their orientation both in regard to the type of patient they accept and their treatment approach. For example, the Sullivan House is designed to treat the most chronic schizophrenic patients, and they are also using and developing a program based on behavioral principles. The patient is introduced to a core treatment team which comprises a clinical administrative psychiatrist, a social worker, a rehabilitation clinician and a head nurse. These are the people who will oversee and coordinate all the various aspects of the patient's care, including psychopharmacological and medical interventions, milieu treatment, family psychoeducation and psychotherapy if indicated and feasible, and all rehabilitative efforts during the inpatient phase of the hospitalization. The patient is also assigned to an individual therapist shortly after admission, who will see him four times a week throughout his stay at the hospital.

When our hypothetical patient has progressed to a point where he seems capable of managing with a less intensive treatment milieu he might move to a level 3 room in his original unit. As is indicated on the flow chart, this entails moving upstairs in their original unit, to a kind of shared apartment-like setting with a common living area and a kitchen. In this setting the patients have less supervision and can get a feel for the various demands of living in the community, such a cooking, cleaning, and communal living, while still officially retaining their

inpatient status. While in a level three room, the rehabilitative efforts are stepped up, while the intensity of nursing interventions is decreased.

The next level of treatment is day treatment. Now the patient can live safely outside of the hospital, but still requires a broad based support system in order to maintain an adequate level of functioning. He may live in one of two types of living situations (flow chart). The first is a supervised living facility, which is a thirty bed house on the hospital grounds,(slide 11), which has one staff member on duty around the clock. The patients would be expected to be able to function relatively independently, to dispense his own medications and to get to his scheduled groups and activities with little or no assistance. Alternately, he might live in an unsupervised living situation near the hospital and come to the hospital daily to attend groups and activities as well as his individual therapy appointments. At this stage of treatment the patient may work part time at a job in the community or at an on grounds job, or he may attend a local community college if he were so inclined.

Finally, our patient has made sufficient connections in the community that he no longer requires the support of the hospital treatment team. The final step is complete discharge from the hospital to "private patient" status. He might elect to remain in the area and continue in individual psychotherapy with his Lodge therapist, or he might leave the area and return home or go elsewhere.

As I mentioned earlier, this is perhaps an ideal scenario and one which unfortunately does not come to pass, or may only be partially successful with the majority of our patients. The treatment may be interrupted prematurely for a variety of reasons: the patient may sign out of the hospital, or his family might remove him, or the financial support for treatment may be depleted. Of course it may simply be that our treatment attempts fail to result in sufficient therapeutic results to allow the patient to progress from one level to the next, and he may be stuck at level one for many months or years. A significant number of schizophrenic patients remain at the day treatment level for a long time and seem to need to maintain a connection to the hospital almost indefinitely to remain stable. They will intermittently have to be readmitted for brief periods when they decompensate.

In designing treatment programs we try to emphasize three primary elements, that is: continuity of care, flexibility and respect for the individual and his or her unique needs. Continuity of care is felt to be a crucial factor which determines good outcome. The next (slide 12) shows the various members of the treatment team and the extent of their involvement in the patient's life and treatment through the different levels of care. As you can see, the individual psychotherapist is the one person who is with the patient all the way through. There is a so-called "administrator-therapist split" maintained during the inpatient phase of the hospitalization. In other words, the administrative psychiatrist manages and oversees essentially all aspects of the patient's treatment program (medications, privileges, milieu treatment, medical issues, etc.) except the individual psychotherapy. The idea is that the therapist and the patient will then be able to work on problems in therapy without the intrusion of more practical, day to day management issues. At the time of discharge to day treatment status, in all but a few cases, the administrative psychiatrist drops out of the picture and the individual therapist assumes this

responsibility. The other treatment team members, including the social worker, nursing staff, rehabilitation case manager and vocational counselor, and group psychotherapist are also indicated on the chart.

This is essentially the state of the treatment of schizophrenic patients at Chestnut Lodge as it exists in 1990. But the Chestnut Lodge of 1990 is significantly different from the Chestnut Lodge of even ten years ago and dramatically different from the Lodge of the 50's or 60's. How did we end up where we are today? What have been the considerations and forces both from within the institution and from without that compelled such changes? The examination of the evolution of this hospital can provide us with some insights into the general topic under consideration, i.e. the combined treatment of schizophrenia with medications and psychotherapy. Before antipsychotic medications were even invented, the early figures at the Lodge, including Frieda Fromm-Reichmann and Harry Stack Sullivan were pioneers in their attempts to apply the discoveries of psychoanalysis to the treatment of schizophrenic patients. When these medications became available in the early 1950's the hospital had to struggle with how and if to integrate these powerful new tools into its treatment methods and philosophy. Delving a bit into the vicissitudes of these struggles over the years was both fascinating and illuminating for me. I am grateful to Drs. John Fort, David Feinsilver, Tom McGlashan, Wells Goodrich, Robert Cohen and Robert Gruber, all of whom have considerably more personal experience and years at the Lodge than do I, who were kind enough to share some of their memories, thoughts and impressions regarding this topic with me in informal discussions.

Chestnut Lodge was opened in 1910, some eighty years ago. Early in its history, the hospital began to devote its efforts to applying the insights gained from psychoanalysis to the treatment of schizophrenic patients. Dr. Dexter Bullard, Sr., who became the director of the hospital in the late 1920's, had a remarkable ability to attract and foster the creative talents of a brilliant group of psychoanalysts in those early years, including Frieda Fromm-Reichmann, Otto Will, Harold Searles, Donald Burnham, Robert and Mabel Cohen, to name only a few. Undoubtedly, you are familiar with their seminal work in the field and I will not detail it here. What is more to the point in our present discussion are the developments since the early 1950's, with the introduction of antipsychotic medications. Clearly the arrival of these medications on the scene started a revolution in American and world psychiatry that we are still living through. Chestnut Lodge, having devoted so much energy to developing skills in the intensive psychotherapy of schizophrenia had now to decide how it would deal with this new force in the therapeutic armamentarium.

The 1960's and 70's were a period of intense and sometimes bitter debate at the Lodge. What developed into standard practice was that almost all schizophrenic patients were taken off medications at the time of admission to the hospital in order to allow a "therapeutic regression" to occur. A regression would in fact ensue in most cases and therapists would work with these patients in four times a week intensive individual psychotherapy, making valiant attempts to understand and connect with the patient and to become familiar with the vicissitudes of their psychotic worlds. At a later stage in the treatment, depending on the progress in psychotherapy, medications would often be instituted. There was a strong opinion, held by a sizable portion of the medical staff that antipsychotic medications took an important element of life out of the

therapeutic process, and caused a unfavorable "sealing over" to occur which negatively impacted on the ability of the patient and therapist to forge a meaningful human relationship hopefully leading to alleviation or cure of their illness. But there was also a present and growing contingent of staff who felt equally as strongly that to deny a psychotic patient relief in the form of psychopharmacological intervention was not only poor clinical practice, but was downright cruel, inhuman and unethical. The debates raged in staff meetings and case conferences for years, and slowly but perceptibly the trend began to change. The results of Tom McGlashan's long-term follow up study, conducted between 1978 and 1983 played a major role in stimulating and catalyzing this change.

In 1983 a specific "Drug committee" was formed to study in a more organized and concerted way the question of medication use at Chestnut Lodge. A small group of senior staff members interviewed all psychiatrists at the hospital to solicit their opinions and experiences, and many of them put their thoughts in writing as well. These written opinions were fascinating to read through and re-emphasized for me the stimulating diversity and depth of thought among the medical staff at the Lodge. The efforts of the committee also helped motivate change and gradually through the 80's changes did occur. There were many other factors at work, including an ongoing momentum paralleling the general trend in American psychiatry during the time, pressures from medical insurance companies and others to reduce lengths of stay, threats of and actual legal action by specific patients, again in line with a growing drift to litigiousness in American medicine. Even if some continued to believe that a drug free period was useful in fostering and cementing a therapeutic relationship, it became riskier to do so because of the threat of possible lawsuits. Today in 1990 I think it is safe to say that Chestnut Lodge uses as much and as broad a variety of psychotropic medications as any other modern hospital in the world. Dr. Quartesan, the organizer of this conference, and I discussed this matter during his visit to Chestnut Lodge in April. He told me that at his clinic they continue to treat some schizophrenic patients off medications during the initial stages of the therapeutic relationship, and that he finds it a useful approach. As I understand it, whatever problems there may be in the Italian mental health system, you do not have to worry about medical insurance companies or malpractice as we do in the States. I was envious when I heard that Dr. Quartesan has the freedom to try such an approach without concern about these factors. In any case, our discussion at the Lodge was brief and I hope that we might have the opportunity to hear more about his experience and to debate the issue here today.

So where does this all lead us? What can we say in regard to the main question at hand, that is how and if to combine psychotherapy with medications in the treatment of schizophrenia? And what sort of psychotherapy are we talking about anyway? In my opinion, we must define psychotherapy broadly when we are dealing with schizophrenic patients. Two people sitting in a room for fifty minutes, two, three or seven times a week is simply inadequate, if that's all the patient is getting. The schizophrenic patient needs more than that, and the extra ingredients must be added with great care and consideration for the needs of the individual. For the most chronic and most severely disturbed patients, a broad based program such as the one I have described at Chestnut Lodge is essential. For less severely disturbed patients, not as much will be necessary. To return again to Dr. Fort's analogy of the arch, one must endeavor to chisel each side stone to conform as closely as possible to the specific psychic foundation that the patient brings to treatment. The two main piers, medications and consistent human relationships are probably necessary for all patients. This relationship does not necessarily have to be with a highly trained psychiatrist or psychoanalyst, however. Rather the important element is the consistency of the relationship. On the other hand, I do believe that every schizophrenic patient deserves a trial of individual psychotherapy if it is economically or otherwise feasible. Unfortunately we are not in a position at this time to predict which patients will respond to such treatment. Of course the same can be said of medications--we would not consider not even trying a medication because it might not be effective. In my experience at the Lodge I have seen several patients whom I would have guessed would be very unlikely to respond to intensive individual psychotherapy, who in fact have benefited from it greatly. One of these is a paranoid schizophrenic man with whom I have been working four times a week for four years who came to Chestnut Lodge after having been through more than twenty previous hospitalizations and who seriously assaulted his therapist at the hospital prior to coming to the Lodge. I had very little hope of effecting much of a change when he arrived, but I have been pleasantly surprised by his slow but steady progress. So I am saying that until we can predict with greater certainty whether psychotherapy may be helpful, give it a try---for two years, for five years, for ten years even. But if it's not working, reconsider its place in the treatment of that patient and perhaps step up other interventions like rehabilitation efforts, family therapy, social skills training, behavior therapy or anything else that may hold some promise of helping the patient along in life. But let us never drop the factor of consistent human relationships in fighting this malignant disease.

I would like to end by quoting from an article that appeared in the American Journal of Psychiatry in 1986<sup>19</sup> titled "Can We Talk." Written by an anonymous schizophrenic patient about her experience in individual psychotherapy, she poignantly captures the anguish of the individual with the disease and he argues for the value of a psychotherapeutic relationship in tempering such anguish.

*"Some accounts that I have read suggest or state that by definition the schizophrenic patient is unable to care about or to fully relate to other people because of an overwhelming fear which drives him inside himself. I know I have the capacity to care but overcoming what seems to be an inborn terror often seems as difficult as scaling a granite wall without ropes....The question of whether the fragile ego of the schizophrenic patient can withstand the rigors of intensive therapy seems to me an unfortunate hindrance to the willingness of psychiatrists to attempt psychotherapy with schizophrenic individuals. A fragile ego left alone remains fragile....Medication or superficial support*

*alone is not a substitute for the feeling that one is understood by another human being...I know I have a long road ahead of me , but I can honestly say that I am no longer without hope."*

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## **NOTES**

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