

Using five extended case studies that demonstrate substantial positive change, the process of change is explored, illustrating a variety of responses to both professional interventions and life events.

The Process of Change in the Chronic Mentally Ill: A Naturalistic Perspective

Joel S. Kanter

Although a variety of treatment interventions has been described in recent years, there have been few discussions of the process of change in the chronic mentally ill. This topic contains an implicit paradox, since *chronicity* suggests an unchanging condition. Although our knowledge of severe mental illness has evolved considerably since Kraepelin (1919) outlined a deteriorating course as a distinguishing feature of schizophrenia, a common belief persists that the prognosis for such conditions is poor without adequate psychopharmacological and psychosocial treatment. Although symptomatic relief can be achieved quickly with the assistance of psychotropic medications, changes in life-styles and personal habits are believed to occur only after prolonged periods of continuing psychosocial intervention.

While most processes of change are elaborated in the context of a specific treatment approach, this chapter examines how positive developments occur in the lives of chronic mentally ill persons encountered in my

An earlier version of this chapter appeared in *Psychosocial Rehabilitation Journal*, 1985, 9 (1), 55-69.

clinical practice. Although my professional relationship with them offers me a vantage point for observation of their lives, my interventions—while significant in some instances—played only a small role in the larger dramas of their development. Thus, I attempt to describe objectively, to the greatest extent possible, their natural evolution over extended periods of time, focusing more on social interaction than psychiatric symptoms. Although I conclude with a discussion of the implications of these cases for treatment, this chapter focuses on the complex interaction of the individual psyche with social environments, life events, and treatment interventions that are involved in the often surprising process of change.

The field of psychiatry has largely ignored—with the exception of idiosyncratic voices such as Wheelis (1973) and Valliant (1977)—how adults change apart from specific therapeutic approaches. This professional neglect has continued in studies of long-term mentally ill persons. Most commonly, the professional literature focuses either on descriptions of various treatment modalities or on outcome, assuming that the prognosis will be poor without professional intervention. Individual cases are both lost in statistical generalizations of empirical studies and highlighted inappropriately to demonstrate the efficacy of specific interventions.

In the naturalistic perspective employed in this chapter, the disturbed person's life outside the treatment setting becomes an essential study topic. This approach has been recently utilized in Sheehan's (1982) journalistic account of a single patient and Estroff's (1981) anthropological study of a small group of patients associated with a particular treatment program (Stein and Test, 1978). Both of these authors eloquently articulate the complex dilemmas encountered by the chronic mentally ill in a manner rarely equaled by mental health professionals. However, Sheehan and Estroff tend to focus more on the persisting difficulties of these persons than their less noticeable positive movement.

Longitudinal Research

The psychiatric literature contains few studies that examine the long-term course of psychotic disorders apart from any particular treatment approach. Manfred Bleuler (1978), Ciompi (1980), and Huber and others (1980), all working in Europe, studied the course of large groups of schizophrenic patients over periods of more than twenty years. These researchers concluded independently that the course of schizophrenic disorders generally progresses unpredictably to a mild end state or recovery. In these longitudinal studies, there was no strong indication for the efficacy of any particular treatment approach, including psychotropic medication. Such conclusions, however, are affected by the tendency for therapeutic factors operative in individual cases to become lost in statistical averages.

In this respect, the work of Bleuler is especially important, as he personally followed more than 200 subjects in his twenty-seven-year study,

observing the salient ameliorative factors influencing individual patients. Beginning his research in the preneuroleptic era, he concluded that "long-term experience . . . revealed one fact most impressively, namely that successful results can be achieved through different methods No single method, in comparison with others, has so much better chances for success that it alone would deserve to be the method of choice. With all methods the result is disappointment, and many of them lead to success . . . the effective therapies for schizophrenia exist in virtually overwhelming multiplicity. They extend all the way from psychoanalysis to brain surgery, from sleep therapy to the employment of the patient in a factory . . ." (p. 441).

Bleuler also noted that, while schizophrenic disorders tend on the average to remain stable after the first five to ten years, a substantial minority of patients change considerably in subsequent years. He observed that many "schizophrenics can still change, improve, and occasionally recover years and decades after onset" (p. 413). Such changes are precipitated by "violent shocks of all kinds . . . (which) . . . awaken the psychic forces, (including) sudden changes from one environment to another, sudden unexpected trust with responsibility," and the illness and death of close relatives (p. 441). While the contemporary literature on stress and schizophrenia focuses on the negative impact of these life events (Dohrenwend and Egri, 1981), Bleuler recognized that these "shocks" frequently have a therapeutic effect.

In several recent papers (Breier and Strauss, 1983 and 1984; Strauss and others, 1985), Strauss and his associates have described a similar naturalistic study of 28 psychiatric patients over two years. The impact of work, social relationships, and the patients' symptom control strategies on their psychiatric disorders was carefully studied using a variety of research instruments. Like Bleuler, Strauss reports that the course of psychotic disorder is an erratic one marked by periods of rapid change as well as moratoriums. His research, highlighting the variable courses of psychotic patients, challenges the widely accepted diathesis-stress model of psychiatric disorder. He notes that "events that could be predicted as stressful, such as a death in the family, may for some people mobilize functioning and reduce symptoms rather than cause decompensation" (Strauss and others, 1985, p. 289). He adds that patients "play an active role in influencing the course of their disorder." Besides controlling their symptoms, they "select their environments (which may be more or less stressful) and collaborate or 'comply' in their treatment (or do not do so)."

Treatment Interventions and the Process of Change

Professionals in community treatment of chronic mental illness have designed intervention strategies without the benefit of research findings that suggest that there are processes of change unrelated to professional efforts. In their respective models of aggressive outreach, psychiatric reha-

bilitation, and aftercare treatment, Stein and Test (1978), Anthony (1979), and Cutler and others (1983) suggest that change occurs in a planned, predictable, and continuous manner in response to *in vivo* interventions in community settings. However, none of these authors provides data to substantiate this hypothesis. In follow-up research on the Program for Assertive Community Treatment (PACT) (Stein and Test, 1980), patient progress was not sustained after discharge from the program, a finding corroborated by Estroff's (1981) naturalistic investigation of the same project. Alternatively, Anthony offers no follow-up data, even of an anecdotal nature, for periods of more than several months. Although we who work in this most complex of professions would prefer that our patients progress in a planned, predictable, and gradual manner, our clinical experience, supported by the research of Bleuler and Strauss, suggests that the process of change frequently does not occur along these lines.

Keeping this perspective in mind, I present five extended case vignettes, with which I have a personal familiarity over at least eighteen months, that illustrate the diversity of change processes. Although these individuals have improved noticeably in social functioning, no significant change in mental status has occurred in at least two instances. In perhaps only one case can a clinical remission be observed. These cases have been especially chosen to highlight often abrupt, unplanned, and unpredictable change processes, and although I have observed similar processes in many cases that improve, these selection criteria do not suggest that I prefer such pathways of change. These vignettes illustrate that the therapist is occasionally successful in implementing more predictable and gradual approaches. However, unexpected life events intermittently occurred that dwarfed the impact of professional intervention. My own interest in a more predictable and gradual treatment process can also be noted in case vignettes described elsewhere (Kanter and Lin, 1980; Kanter, 1984). Thus, these vignettes should not be interpreted as arguments for or against any particular treatment model.

Case 1. Judy R., a 35-year-old single woman, had been schizophrenic and had functioned minimally since adolescence. An unattractive woman with no social contacts, she was involved in a dependent and conflictual relationship with her extroverted mother. Although she had taken medication and had experienced psychotherapy and day treatment for many years, her condition had changed little. She had, however, trained many staff members to cope with their feelings of helplessness.

Judy's mother was diagnosed as suffering from terminal breast cancer. Judy immediately became depressed and insisted on returning to the state hospital, where she stayed for six weeks. Professionals who knew her were pessimistic about her outcome, fearing that her mother's death would cause her condition to deteriorate. She had not made a decision on her own in twenty years. Judy would engage her mother's opinion in

matters such as buying clothes, and would then insist on some bizarre course of action that would lead to conflict. She would act this way to a lesser extent with others as well.

In spite of these difficulties, staff members of her aftercare program attempted to develop a residential placement as her mother's health worsened. Agreeing that she would not be capable of supervised apartment living, the staff made several attempts to find suitable foster homes. However, either sponsors rejected her or she rejected them. As her mother's health deteriorated, Judy withdrew from day treatment activities, foreshadowing another relapse. Meetings were held with her brother and sister-in-law to orient them to her condition and available services.

However, instead of deteriorating, Judy became seriously involved in the task of nursing her now-invalid mother. Both parties received satisfaction from her activity, and, in her last weeks, her previously critical mother verbally expressed her appreciation. After a brief hospital stay, Mrs. R. passed away, and interested staff members anticipated a relapse as Judy remained alone in the house. Before they could intervene, Judy and her brother presented a plan to sell their mother's house and for Judy to move into a small apartment with her brother's support. This plan was implemented successfully, and she functioned in this setting with only minimal support from her brother and the clinic, including medication and occasional recreational activities. Eighteen months after her mother's death, these gains had continued.

Although Judy's improved functioning might be understood using a family systems theory that viewed her conflictual relationship with her mother as a central factor in her illness, this theoretical model does not account for her poor functioning in treatment milieu settings that were less reactive, or her continued schizophrenic condition after her mother's death. Perhaps only her mother's illness activated the latent capabilities for more independent functioning in later years.

Case 2. Laura A., a 34-year-old divorced woman, had been hospitalized for acute psychotic conditions six times in the past seven years. Recovering with medication, she ignored recommendations for outpatient treatment and resumed a relatively isolated existence, working at clerical positions beneath her intellectual potential. Her life-style involved frequent geographical relocations, often to care for a narcissistic and mentally ill mother. On several occasions, she was sexually assaulted, partly due to poor judgment in choice of companions.

At 33, she again relapsed, becoming delusional after the loss of a beloved pet. She traveled to a nearby rural area, where she rummaged through a long-abandoned house previously owned by her grandmother. Taking some mementos home in her car, she stopped at a nearby gas station owned by the new property owner. Noting the items in her car, he called the police and Laura was arrested for the theft of \$200 worth of

property. After spending a week in an uncomfortable rural jail, she was transferred to a state hospital for a forensic evaluation. Six weeks later, she was finally discharged with legal charges still pending.

On this occasion, she accepted the recommendation for aftercare treatment and contacted the mental health center, partly for assistance with her legal problems. Finding her initial psychiatrist helpful, she remained on medication and accepted a transfer to a new therapist and psychiatrist. Within a few weeks of her discharge, she had obtained a highly skilled clerical position with a previous employer. She continued to work for two-and-a-half years, and was promoted to a supervisory position. Working overtime, she paid off large debts, including legal expenses. She also limited her mother's exploitation—her mother had earlier spent weekends in her small apartment. Slowly, with the help of weekly individual psychotherapy sessions, she expanded her social network and increased her recreational activities.

In her therapy, she viewed her progress with guarded relief. Fearing relapse, she resisted her psychiatrist's suggestion to slowly reduce her medication. She admitted that the humiliation of her incarceration encouraged her to cooperate with treatment. She aptly noted that any criminal who committed the same minor offense would probably have been released on his recognizance and sentenced only to probation, whereas she had been incarcerated, fined, and left with large legal fees.

In this case, a different type of shock led to a more collaborative attitude toward psychiatric treatment. Recognizing her tendency toward psychosis, Laura learned to take appropriate preventive measures that involved both medication and control of stress. The latter measure led to a more guarded attitude toward social relationships, especially romantic ones, but these defences are becoming more adaptive with the help of psychotherapy.

Case 3. Carol T., a 28-year-old single woman, had been a client at the mental health clinic for nearly ten years. With a history of severe behavior problems over more than twenty years compounded by borderline retardation, this troubled woman had spent much of her childhood in various institutions and much of her adult life enmeshed in a multiproblem family milieu. Alternatively engaging, exploitative, and abusive, Carol had received nearly every service offered by the clinic including individual therapy, family therapy (conducted at home), medication, day treatment, and supervised apartment living. Though not psychotic, she had been repeatedly hospitalized in several local hospitals, and was involved with almost every social agency in her community. Creating conflicts and crises in most of her relationships, Carol had frustrated the efforts of most helping professionals who knew her.

After her dedicated therapist left the clinic, the new case manager, in consultation with unit director, decided to significantly restrict her

previously daily contact with the clinic to a weekly psychotherapy session and monthly medication follow-up. Although Carol employed many strategies to secure more attention, a consistent lack of reinforcement led to a rapid decline in her disruptive behavior over the next ten months. During this time, without any encouragement from her therapist/case manager, she removed herself from her difficult family situation and moved to an apartment with two other clinic patients.

Eight months after beginning treatment with the new case manager, Carol asked the unit director for a new therapist when the case manager refused to accept her invitation to dinner in her apartment. This request was denied and she was encouraged to continue her treatment with this staff member or to seek assistance elsewhere. One month later, Carol informed the clinic that she was doing well and no longer needed its services, and her case was soon closed.

A month later, she began to barrage the clinic's emergency service with crises and requests for hospitalization. She was briefly hospitalized after brandishing a penknife in a nearby hospital emergency room. Soon after discharge, she again sought assistance from the clinic, asking to be rehospitalized, as she had no place to live after a conflict with a roommate. When this request was refused, she assaulted a staff member and was arrested by the police. After several days in jail, she was released at a hearing where a peace bond of \$500 was established with the conditions that she (1) display good behavior for one year and (2) comply with the rules of the mental health center.

During the next three tumultuous months, in which she threatened suicide and was arrested at the clinic for trespassing, Carol engaged the assistance of her roommate's aunt, who had acted as her advocate in the preceding months. This assertive woman contacted local politicians who in turn pressured the clinic director to reopen her case. Because the clinic was facing an imminent reaccreditation, her case was promptly reopened and assigned to a clinic psychiatrist. In her second session, she informed the psychiatrist that her roommate's aunt, who had decided that the clinic was heartless and inept, had decided to move Carol to an efficiency apartment in a neighboring jurisdiction. Three weeks later, she began a three-day campaign against the clinic, beginning with harassing phone calls and culminating in a visit to the center's emergency service, where she was again arrested for trespassing.

Soon after this arrest—eighteen months after she was assigned a new case manager—Carol moved into her own apartment and the ex-roommate's aunt became her *de facto* case manager. In the months following, she politely contacted center staff several times, asking that her records be transferred to another clinic. About eighteen months after this move, she returned to the area, renting an apartment adjacent to the clinic. She has maintained a stable existence in the community without any mental

health services, cares for a retarded child, and has achieved a fifty-pound weight loss.

Analyzing this unusual outcome is probably impossible, although the tumultuous confrontation with the mental health clinic that resulted in several arrests appears to have been a turning point in Carol's social functioning. Her roommate's aunt's assistance in response to her "persecution" by an "uncaring and depriving" clinic has also apparently played a central role in her rehabilitation.

Case 4. Alan Z., a 37-year-old married father of one, was born and raised in an Asian nation before coming to this country to attend college. A brilliant student, he completed all doctoral requirements except his thesis in a social science field, and became a charismatic instructor at a small liberal arts college. There he became romantically involved with an undergraduate student. He obtained a new position at another university and she transferred to a nearby institution to continue their relationship.

After his girlfriend was graduated from college, Alan became floridly psychotic and returned to his birthplace and family for psychiatric treatment. Because his girlfriend was ineligible to join him, he returned to the United States. Several months later, while still convalescing from his psychosis, they were married, partly to enable him to obtain her employment insurance benefits. Over the next year, he functioned in a clerical position until he began to have conflicts with one of his superiors. After leaving this position, he filed a discrimination lawsuit that was settled for a moderate sum, and used the money for a down payment on a house.

Over the next few years, Alan's condition deteriorated considerably as his attempts to regain an acceptable social role failed. His wife left him temporarily, returning when he improved after a brief hospitalization. Soon they conceived a child, and after the birth of their son, Alan stopped taking his medication. Nine months later his wife again moved to her own apartment, and during the next eighteen months, he became increasingly reclusive as his schizophrenic condition continued. He remained home, going out weekly for groceries and avoiding any social contact. With his wife's assistance, he maintained this marginal existence.

At this point, their bank threatened foreclosure on the home, since the couple had not made payments for many months. Alan's wife sought professional consultation, expressing her conflicting feelings of loyalty, helplessness, and despair. Although she had invested many years of her life in Alan, she realized that her first priority had to be their son and herself. Since her husband had not cooperated in any activity, she believed that he would not agree to sell the house before foreclosure, thus avoiding a loss of valuable equity. She asked if there was a legal route for becoming his guardian, enabling her to sell the house herself. At the same time, she feared that such actions might increase the conflict between them. She also explored ways to obtain treatment for him, hoping that he would recover in time to recognize their financial plight.

After two consultations, it was concluded that these measures would be risky and improbable, and would also require an aggressiveness toward her husband that would make her uncomfortable. The amount of money involved, although not insubstantial, was not essential to her simple life-style. She terminated the meetings, feeling more accepting of her decision to let the foreclosure take its course.

A week later, Mrs. Z. contacted the consultant, informing him that she had contacted the bank and succeeded in postponing the foreclosure until she had explored options for selling the house. She then had obtained a commitment order from a court system known for its defense of patients' rights, and had persuaded her husband to resume psychiatric treatment and medication.

Six weeks later, her husband had agreed to sell the house and sign a separation agreement that would award her and the child the proceeds, thus enabling his Social Security payments to continue without interruption. Alan continued in treatment twice monthly, became involved in daily volunteer work, and assisted her in preparing the house for sale. The house was sold for a good price and Alan moved into his own apartment.

Eighteen months after this crisis developed, Alan's situation continues to improve slowly, and he continues psychiatric treatment and volunteer work. Although they still live separately, he visits his wife almost every day and has assumed major responsibility for his son's child care. Encouraged by his gradual progress, his wife is not filing for divorce and is receptive to the possibility that their marriage may be salvaged.

This vignette illustrates how a potentially disastrous situation, conceivably resulting in Alan's homelessness, provided the psychic shock that motivated his wife to take decisive action. It is questionable whether any planned intervention could have achieved the same outcome. His wife later reported that the consultation sessions were valuable to her and had a major impact on her subsequent actions. Although they could be interpreted as utilizing a paradoxical technique, I believe that the empathic appreciation of the wife's dilemma enabled her to utilize previously unrealized resources.

Case 5. Oliver M., a 32-year-old single man, had an eleven-year history of schizophrenic illness, marked by intermittent periods of florid psychosis and residual states marked by continuing auditory hallucinations. During this time, he was hospitalized six times and was treated with very little success as an outpatient with an array of modalities, including individual and group therapy, a number of medications, and orthomolecular therapy. He also had a tendency to drink too much.

Although he made sporadic attempts at independence and employment for the first five years of his illness, Oliver had functioned poorly from age 26 to 32, living with his parents and maintaining a small circle of acquaintances with other psychiatric patients. Several months after beginning individual psychotherapy and medication with a new psychiatrist, he

was again hospitalized after being detained by the police for hostile behavior while intoxicated. His parents were then referred by the psychiatrist for family consultations with another professional. They were helplessly exasperated by his continuing difficulties and wondered how they could manage him more effectively. They were especially concerned about his idleness, poor smoking etiquette, financial exploitation (in spite of a large disability check), and alcohol abuse.

As Oliver's parents maintained more consistent expectations over the next three months, he moved in with a girlfriend who had been a fellow patient during his recent hospitalization. Although prone to depression and suffering from persistent physical ailments, she worked steadily at a local store. Since she worked an evening shift, Oliver returned home for dinner on most days. He continued his psychiatric treatment and his parents participated in monthly consultations to discuss their frequent contacts. In these meetings, for example, they decided to insist that he wash the dishes each night in exchange for dinner.

Nine months after the last hospitalization, he began working part-time for several months, an interest stimulated by his engagement to his girlfriend. One year after his discharge, they were married in a church ceremony attended by both family and friends. Although the parents had considerable anxiety about their son's marriage, they liked their daughter-in-law and perceived her as a stabilizing influence.

In the months following the meeting, Oliver's dependency on his parents declined and he visited them less frequently. Three months after the wedding, he received notice that his disability payments were being terminated, as he was determined to be able to work. Instead of appealing this decision, he began to look seriously for employment and, with the help of a rehabilitation counselor, obtained a full-time entry-level clerical position.

Since his finances were limited with this low-paying job, he discontinued his treatment and medication, but suffered no regression. Six months later, experiencing some distress, he resumed treatment on his own volition for the first time and is continuing monthly medication consultations.

Oliver's wife soon became pregnant. They wanted a family and made careful financial preparations to enable them to afford this change. After supporting his wife through her pregnancy and attending childbirth classes, he assisted in the delivery of his daughter nearly three years after his last hospitalization. With childcare help from his now-retired parents, the couple is successfully raising the child while employed full-time. While residual symptoms occasionally intrude, they are controlled with medication and do not interfere with his functioning.

While individual and family treatment were important factors, Oliver's relationship with his wife and loss of disability benefits played a pivotal role in this major transformation. Perhaps the individual treatment aided

him in pursuing an intimate relationship while the family intervention facilitated his independence. His supportive marital relationship, enhanced by the resultant increase in self-esteem after a joyous wedding attended by his social network, may have enhanced his ability to overcome the challenge of losing his benefits. The rewards of successful functioning as husband, father, and member of his extended family have encouraged him in coping effectively with the responsibilities of daily living.

Factors in the Change Process

As indicated in the above vignettes, the process of change in long-term mentally ill individuals is often not a planned, predictable response to aggressive treatment interventions. In most of these case studies, life events external to treatment played a major role in precipitating the change process, stimulating dormant adaptive capabilities. The role of treatment interventions generally was secondary, and in many cases prepared patients and families for more successful exploitation of these unpredictable occurrences.

In some cases, such as Laura's and Alan's, treatment after a major psychic shock assisted the patient in consolidating and maintaining his or her gains, yet such interventions did not utilize a carefully planned agenda. In yet other cases, such as Carol's, change resulted as much as a reaction against treatment as a response to treatment. In such instances, as well as Alan's, substantial gains were made after the termination of a treatment intervention.

In all these situations, psychic shocks—both related and unrelated to therapeutic activities—preceded periods of substantial change in psychological and social functioning. During other periods in these individuals' lives, there was a more gradual and predictable change, as in the months that followed Laura's return to the community.

Given this diversity of change processes, I question attempts to dictate treatment procedures with the chronic mentally ill that imply a particular process of change. For example, Anthony and others (1982), writing for mental health administrators, enumerate ten essential ingredients of psychosocial rehabilitation programs. Outlining technical guidelines that can easily be used in accreditation programs, they state that "rehabilitation is not defined by where a service is provided, but rather by what service is provided" (p. 94).

While I agree that treatment location is irrelevant, I disagree strongly with the suggestion that the nature of the service defines rehabilitation. Although the authors stress the importance of client participation, they suggest that what is done to the client may be more essential than what happens to the client. The cases discussed above offer strong evidence that rehabilitative processes frequently occur in the absence of formalized, sys-

tematic rehabilitation strategies. Physical rehabilitation provides an analogy that emphasizes this distinction. For example, one patient recovering from a broken bone might be offered specific exercises under the supervision of a physical therapist, while another might restore muscle tone during normal activity or recreation. The experience of the organism defines the rehabilitation process, not a specific technical procedure—such as rehabilitation plans with timetables for goal achievement—that may encourage this process.

Implications for Treatment

However, a frame of reference centered on the client rather than the treatment leads to difficulties in transmitting treatment skills or evaluating professional competency. If the process of change is merely an erratic reaction to various life events and eclectic therapeutic or rehabilitative interventions, then of what value is our professional training and experience? In most of the cases outlined above, specific interventions apparently failed or precipitated unpredictable reactions. Are there, then, any conclusions that can be drawn from these experiences that can enhance our practice with this difficult clientele?

Several hypotheses about effective treatment strategies can be deduced from these experiences. First, all interventions with clients and their social networks are empirical trial-and-error processes. Through continuing observation and interaction with the client, the therapist should learn how to intervene with increasing effectiveness. This process requires an openness to clinical data that does not coincide with predicted responses.

Professionals should also begin to appreciate the limitations of their therapeutic powers and learn to conserve their energies for interventions at critical moments when the client and social network may be more receptive. An opportunistic attitude seems important for success in this field. Unfortunately, many professionals are impatient and withdraw prematurely from the client when they do not receive the desired response. When the type of life events outlined earlier occur, a trusted and knowledgeable professional's presence can maximize the possibility of an adaptive response. Time-limited approaches and programs implicitly reduce the possibility of such interventions (Kanter, 1983).

Finally, the importance of consultations with interested relatives is described in Chapters One and Two in this volume and in Kanter and Lin, (1980). In the cases of Alan and to a lesser extent Oliver, relatives administered psychic shocks that precipitated important changes. Although these relatives proceeded out of desperation, an outsider cannot easily feel the sense of commitment that enables one to take these very personal risks. However, similar intense involvements often occur in residential settings, such as hospital wards and group homes, that function as surrogate fam-

ilies, leading in some instances to similar responses (Bergman, 1982; Climo, 1983). Alternatively, these families, as in the cases of Judy, Alan, and Oliver, offered valuable growth-enhancing support over time that enabled relatives to experience a sense of satisfaction rather than exploitation. In most of these situations, professional guidance and encouragement assisted these concerned parties in effectively and economically helping their troubled family members.

In summary, I agree with Manfred Bleuler's (1978) conclusion after a lifetime of professional practice with the chronic mentally ill that "the active communal relationship seems . . . to be the most important principle of treatment. It consists of a communal relationship with the doctor, with the nurses and warders, with other patients, with the family members, or with anyone at all In a communal relationship, the patient's own talents, strengths, and interests should unfold and have their being" (p. 441). There can be little question about the therapeutic significance of Judy's brother, Carol's roommate's aunt, and Oliver's wife. All these persons entered or reentered the clients' lives as a result of unpredictable life events or crises and played an important role in their progress. The concerned professional should be continually searching for opportunities to encourage such relationships. These interventions require professionals to pay more attention to their clients and their clients' social networks than to their theoretical orientations or treatment techniques.

References

- Anthony, W. *The Principles of Psychiatric Rehabilitation*. Baltimore: University Park Press, 1979.
- Anthony, W., Cohen, M., and Farkas, M. "A Psychiatric Rehabilitation Treatment Program: Can I Recognize One if I See One?" 1982, *18* (2), 83-96.
- Bergman, J. "Paradoxical Interventions with People Who Insist on Acting Crazy." *American Journal of Psychotherapy*, 1982, *36* (2), 214-222.
- Bleuler, M. *The Schizophrenic Disorders: Long-Term Patient and Family Studies*. New Haven: Yale University Press, 1978.
- Breier, A., and Strauss, J. "Self-Control in Psychotic Disorders." *Archives of General Psychiatry*, 1983, *40*, 1141-1145.
- Breier, A., and Strauss, J. "Social Relationships in the Recovery From Psychotic Disorder." *American Journal of Psychiatry*, 1984, *141* (8), 949-955.
- Ciampi, L. "The Natural History of Schizophrenia in the Long Term." *British Journal of Psychiatry*, 1980, *136*, 413-420.
- Climo, L. "Helping Some State Hospital Mental Patients Make Small But Necessary Changes: Transference Openings from Countertransference Traps." *Community Mental Health Journal*, 1983, *19* (2), 129-136.
- Cutler, D., Terwilliger, W., and Faulkner, L. "Integrating an Aftercare Plan for the Chronic Patient." In D. Cutler (Ed.), *Effective Aftercare for the 1980s*. New Directions for Mental Health Services, no. 19. San Francisco: Jossey-Bass, 1983.
- Dohrenwend, B., and Egri, G. "Recent Stressful Life Events and Episodes of Schizophrenia." *Schizophrenia Bulletin*, 1981, *7* (1), 12-23.

- Estroff, S. *Making It Crazy: An Ethnography of Psychiatric Clients in an American Community*. Berkeley: University of California Press, 1981.
- Huber, G., Gross, G., Schuttler, R., and Linz, M. "Longitudinal Studies of Schizophrenic Patients." *Schizophrenia Bulletin*, 1980, (4), 592-605.
- Kanter, J. "Reevaluation of Task-Centered Social Work Practice." *Clinical Social Work Journal*, 1983, 11 (3), 228-244.
- Kanter, J. "Resocialization in Schizophrenia: Renegotiating the Latency Era." *International Review of Psycho-Analysis*, 1984, 11 (1), 43-59.
- Kanter, J., and Lin, A. "Facilitating a Therapeutic Milieu in the Families of Schizophrenics." *Psychiatry*, 1980, 43, 106-119.
- Kraepelin, E. *Dementia Praecox*. Edinburgh: Livingstone, 1919.
- Sheehan, S. *Is There No Place On Earth For Me?* New York: Houghton Mifflin, 1982.
- Stein, L., and Test, M. A. "Alternative to Mental Hospital Treatment." In L. Stein and M. A. Test (Eds.), *Alternatives to Mental Hospital Treatment*. New York; Plenum, 1978.
- Stein, L., and Test, M. A. "An Alternative to Mental Hospital Treatment. I. Conceptual Model, Treatment Program, Clinical Evaluation." *Archives of General Psychiatry*, 1980, 37, 392-397.
- Strauss, J., Hafez, H., Lieberman, P., and Harding, C. "The Course of Psychiatric Disorder: III. Longitudinal Principles." *American Journal of Psychiatry*, 1985, 142 (3), 289-296.
- Vaillant, G. *Adaptation to Life*. New York: Little, Brown, 1977.
- Wheelis, A. *How People Change*. New York: Harper, 1973.

Joel S. Kanter is a faculty member of the Washington School of Psychiatry and team leader of Services to the Socially Isolated, Community Care Unit, Mount Vernon Center for Community Mental Health in Alexandria, Virginia.