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Client Directed Recovery,

A Humanistic Approach to Schizophrenia

Client Directed Recovery is a disarmingly simple method for developing self recovery in schizophrenia, manic and depressive behaviour and some allied disruptions in human life. Through a small number of uncomplicated methods, we learn to unravel the meaning and hence the reinforcers, of these elements in our lives.

The CDR process has its beginnings almost twenty years ago in observations which I made while working on the wards of a state mental hospital. Commonly, ward attendants and other workers would be confronted with a patient having a psychotic experience which was disruptive to the ward. Many of us found that "talking the patient down" was easier than using a straight jacket or, later, drugs. Some of us even found this process more humane.

Being a curious person and a tinkerer, I began to identify those things that seemed to work best, like responding warmly and being safe for the patient; talking about things that the patient would focus on with interest; confronting with visual images of less stressful things like the ten thousand foot mountain that rose immediately behind the hospital. It soon became obvious, as it has to many workers on many hospital wards, that to focus away from the distress and from the source of the distress, which was associated with the psychosis, reduced its intensity, or abated it altogether.

Then the tinkerer in me, being unsatisfied, worked to teach the whole process to the patient. In many cases this worked well, and I suspect that many others have done the same, although I know of none. One further advantage became apparent: the patient that was able to use this process was no longer dependent upon me or the hospital staff. In some instances the patient was able to remain in situations which previously produced a psychotic reaction simply by shifting the focus of attention to nondistressing subjects - and back to the situation.

I found that this approach met with varying degrees of success, so I tinkered some more. I found that talking with a patient about a psychotic episode would often reinstate it, sometimes partially and occasionally completely. I found that short trips close or into the psychosis, followed by the already demonstrated ways out, taught the patient two important things; that they can develop the skills to enter and abate psychosis; that psychosis is not such a scary experience. The development of such an easy method to train a psychotic patient to have charge over the "mysteries" of schizophrenia further extended its usefulness. Patients could reinforce themselves in non psychotic behaviour.

Patients that found schizophrenia no longer scary had less trouble with the process and less recurrence of the psychotic episode. This led me to the suspicion that feelings states determined the presence or absence of psychosis, and I began to pay more attention to training patients to be aware of their feelings states and how they can alter them with ease. A basic method we use is to focus attention upon those things which produce the feelings state which might be desired at the moment. Identifying the central role of feelings states gave me more tools to share with my patients. At present in the CDR Program we teach innumerable methods for altering feelings states, and clients select those with which they feel most comfortable. We also have learned to develop in the group a climate that says loud and clear that there are several special things about those of us who are able to become psychotic. We have a surprising number of inventive and creative fellows.

It is my experience that fear is the feelings state that produces the psychotic experience. Always. Even when the emotional state is outwardly depression or anger, for instance. The excellent abilities which most of my clients have developed has enabled them to identify fear as directly connected with whatever feelings state is the most obvious to the psychotic client and to the observers. Thus, reducing the fear of psychosis has reduced the incidence of psychosis. The implication is, of course, that fear of psychosis is a major cause of psychosis. I know of few workers that do not experience that the anxiety about becoming psychotic precipitates psychosis. Further, during psychosis, the experience itself is so frightening that it intensifies itself exactly like the feedback when a microphone is exposed to a nearby loud speaker.

The two elements, training in feelings state alteration and the development of a climate in which psychosis is a mark of being special, are central to the CDR groups. However, an experience with a group of chronic schizophrenic outpatients produced another factor which we use, which seems to integrate the whole process.

What I discovered with these patients is that their behaviour is largely devoted to two things; ritualistic behaviour which is designed to keep the patient from psychosis producing feelings states and situations; psychotic episodes which have definite interpersonal meaning. In a very rigid way, these patients were doing exactly what I had been training other patients to do in a more flexible way. These patients, too, were accomplishing this in ways which were interrupting their lives. Since they were already skilled in going in and out of psychosis as they seemed to find the need, I decided to see whether I could help them discover how they were using psychosis, which was so obvious to those around them. For this I used one simple concept, and built the whole history of the group around it - the interpersonal meaning of the psychotic episode.

We began with a development of the interpersonal meaning of almost all behaviour (one resident of a church nursing home said, "It's like when I pour tea for the ladies at my table"), and the further thought that much (or most?)

behaviour occurs *because* of its interpersonal meaning. In twelve sessions with ten patients there were two dramatic shifts to other behaviour than psychosis, to produce the same interpersonal effect. Some years later, when I read the work of Thomas Szasz, I had a stronger sense of what I had put together. The fact is that I wasn't teaching the person with psychotic experience anything new. I suspect that all but a few "psychotics" have learned to precipitate their psychotic experiences for their own particular interpersonal purpose.

At this point it is vital to point out that the skills which I was for several years helping patients to develop was often already well developed, especially in chronics. All I was doing was making it aware behaviour, and thus CHOSEN behaviour.

Our Client Directed Recovery Program works well with some, not with all schizophrenics. We are not yet researchers, so our results are coloured by what we think we see. There is no question that we are producing results, some startlingly extensive, and some in unanticipated directions. I think it is the mark of a true humanistic and client directed approach, that when Ralph became fully aware of the elements of his thirty years of schizophrenia, and that this alternative was to leave his mother's safe side and go "out there", he elected to remain "schizophrenic". I am sure that he is convinced that you have to be crazy to go "out there" and struggle for the things Ralph has given to him. In contrast with most evaluators, I would say that CDR worked well with Ralph. He made a clear choice to continue what he had been doing unawarely for thirty years.
