Case Studies of the Anne Sippi Clinic

No. I. Anne Sippi Miriam Siegler, M.A., Jack Rosberg, M.A., and Chess Brodnick, M.A. 1

This is the first in a series of projected case studies of schizophrenic patients in treatment at the Anne Sippi Clinic in Los Angeles. The Clinic was created by Anne's mother, Mrs. Jane Henderson, and Jack Rosberg, M.A., in cooperation with Anne's doctor, Harvey Ross, M.D., to serve severely ill schizophrenic patients like Anne who may require more than one modality of treatment. The chief modality of treatment at the Clinic is "direct confrontation," a psychotherapeutic technique developed by Jack Rosberg, M.A., Director of Treatment. This case study reports Anne Sippi's treatment by direct confrontation, as well as the HOD and EWI tests which have been used to monitor her treatment (Kelm, 1967; El-Meligi, 1970).

Anne's History

Anne was born January 2,1952. Her birth was one month premature; she weighed four pounds eight ounces. Anne's mother believes that this occurred because her doctor put her on a crash weight-reducing diet at the end of the pregnancy. Anne was in a premature nursery for three weeks before coming home. She seemed normal, and her development for the first year was normal.

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When Anne was a year old, her parents moved to a street where there were many other children. Anne was afraid of the other children and backed away from them. Her mother's efforts to make her more comfortable about this were not successful. At this time, Anne did crib-rocking.

Anne did not talk until she was two-and-a-half years old. At four, she held her hands over her ears in nursery school. The school recognized that something was wrong and recommended a psychologist, who told Anne's mother that it was "too late"—she should have been seen when she was two!

In kindergarten, Anne still held her hands over her ears. She also hit other children. She spent a second year in kindergarten. At six, she was placed in a special education class in the public school. She started piano and violin lessons at this time.

At 13, Anne saw a psychiatrist at the insistence of the school. She was diagnosed as schizophrenic and given Mellaril. The diagnosis was meaningless to Anne's parents, because they knew nothing about the illness, were told nothing, and did not know what questions to ask.

Anne entered junior high school. She took up the viola, mastering the new clef without difficulty. She played in the school orchestra, enjoyed coloring, painting by number, dancing to rock music, and taking long baths. Her relation with other children

had not improved; she crossed out the pictures of children's faces in the school books. She had no friends.

At 15, Anne entered public high school. Again, she played in the orchestra. She began to seriously withdraw, going to bed at 6:00 p.m. each evening. A psychiatrist recommended that she be sent to a residential school for the retarded, where she stayed for 10 months. When she came home, she was badly regressed.

At age 17, Anne would wander off from home. She was afraid of cars. Her parents tried to hospitalize her, but were unsuccessful. She began to see a psychiatrist four times a week, and had additional sessions with his nurse to "socialize" her. After one of these sessions she and her mother returned home to find that her father had killed himself. In retrospect, it seems likely that Anne's father also had a severe psychiatric illness. He suffered from mood swings and had been hospitalized several times. But the family had fared even worse in getting useful information about his illness than about Anne's. He was never given a definite diagnosis.

Anne's condition did not improve, and in 1973, at the suggestion of a friend, Anne started treatment with an Orthomolecular psychiatrist, Dr. Harvey Ross. She did not progress dramatically on the vitamin treatment. Her behavior was often assaultive, communication with her was nearly impossible, and her prognosis was very poor. It seemed as if she was slated for custodial care. Her doctor fortunately recognized the need for urgent intervention lest her destructive behavior cut her off from further help. In September of 1974, he recommended that she begin direct confrontation treatment with Jack Rosberg. In making this move, Dr. Ross set the stage for the creation of the Anne Sippi Clinic.

When Jack first met Anne, she was a patient at a small private psychiatric hospital. At this time, she was delusional, and she heard the voices of her dead father and other people from her past and talked back to them. She talked to plants. She was self-mutilating as well as assaultive, and was in restraints 70 percent of the time. When Jack first saw Anne, on the patio of the hospital, he said to her: "I hear that you bite people and tear their hair! Well, I do, too!" Anne was taken aback by this.

Jack decided that Anne was treatable on the grounds that he was able to get a response from her, and a person who can respond can become responsible. Jack's method echoes that of the nineteenth-century "moral treatment" psychiatrists who placed great emphasis on whether or not they could "catch the patient's eye." Having been assured that he could catch and hold Anne's attention, Jack believed that she could progress, but it was unknown how much.

At this time, Anne's vocabulary had shrunk to a few words: "Oh," "O.K.," "Yes," "No," and occasionally, "ice cream." She held up her fingers in a circle in front of her face; she later told us this meant "dirty cunt." Her affect was flat and she appeared to be retarded, but when she was angry, she came to life.

Anne now entered "marathon therapy." She was seen seven days a week in sessions lasting from 45 minutes to two hours, at intervals throughout the day. Whenever Jack had any free time between his other patients, he would go to the hospital (which was next door to his office) and "go after" her. After three weeks of this treatment, Anne showed some fear and apprehension about what was happening. There was less acting out. She was moved from the closed ward to an open ward of the hospital. She started to come out of her room from time to time, and she stopped biting people.

Chess and Leora Brodnick joined Anne's treatment team and started to work with her on a daily basis. They took her for the day after Jack's opening session with her. They reintroduced her to the world. They took her to parks, beaches, restaurants, the May Company, and so forth. They often took Anne to their own apartment. Anne was now more often angry, and used more words. Instead of the rigid yes-no type of answer, she now began to argue and converse. She seemed very quick and sharp, and lost her retarded demeanor.

At first, Anne was very happy to go on the

outings with Chess and Leora, very complacent about her good fortune. She was only anxious occasionally. She was doing so well that it was thought she could be discharged from the hospital. Anne had other ideas. In February, 1975, she precipitated a scene in the May Company, screaming and pulling her hair. Chess and Leora were forced to call a security guard to help them get Anne out of the store (and to make it clear that they were not maltreating this poor child!). Anne went to her home, where she seemed to be all right for two or three weeks and even helped with the housework, jack called on Saturdays and Sundays to see how she was faring; the rest of the week, Chess and Leora picked her up and brought her to the Clinic as usual.

Both conceptually and on a feeling level, Anne began to understand the consistency and determination of her therapists in bringing her back into the world again. Her resistance stiffened, and she now refused to come out of the house voluntarily to go to the office. She demonstrated that she could throw up at will (which she did with great effect at the dinner table). She began to urinate everywhere: in her bed, in the car, in the office. Jack stopped this by putting some lemon juice in a paper cup, cornering her and telling her that he was going to force her to drink this "pee" if she didn't mend her ways. She stopped this, but began to put the caf s feces and food under her pillow and to defecate in the shower. These maneuvers made her so uncomfortable and seemed so halfhearted that they were ignored, and she soon stopped. On one occasion when her family was planning to go out without taking her, she ripped an earring out of her ear. On another occasion, she rode her bike to the beach, was picked up by the police and taken to County Hospital. Finally, Anne disappeared from a family outing at the beach in her bikini and stayed away for three days. This caused the desired amount of consternation in her family and her devoted therapists, who wondered if they had lost her forever. However, she turned up three days later, having met a nice young couple who had given her some clothes and a bus pass. She returned to the hospital for one year.

The therapeutic battle now began in earnest. Anne had a topsy-turvy set of values: "fun" was screaming, hitting, and upsetting others; "punishment" was going to the movies or the park. She spoiled any fun that she might have had. She spoke of herself in the third person and avoided any responsibility for what happened to her. She used other people only to act up against them and get them to put her away. Her therapists worked to reverse this: Anne had to be got to take responsibility for what happened to her, rather than experiencing herself only as someone who was acted upon, for good or ill, by the outside world. She had to be made to feel that she could make her own fun. SHe had to be intrigued, made curious, seduced with the delights of the outside world, so that she would see it as a possible source of good things for her. The pattern of institutionalization had to be broken.

Jack and Chess decided that since Anne could not as yet control her own impulses, they would do this for her. She developed a healthy respect for their authority! Anything remotely "good" in her behavior was now generously rewarded, anything "bad" rigorously suppressed. She was not allowed to act badly. Meanwhile, Chess worked on getting Anne to say why she did things. He questioned her about everything: "Why did you say that? Why did you do that?" so that she would begin to feel that she was making choices whether she admitted it or not.

By the end of 1975, Anne began to show some interest and concern for others. She found that she could inspire people by being nice to them, instead of feeling that she could only inspire them by acting crazy, frightening them, or inducing pity. In June, 1976, plans were made to move Anne out of the hospital to a board-and-care home. She was taken three times a week to her new home in order to get used to it. She was frightened, and all her earlier behavior returned, but she was told that no matter what she did, she would be leaving the hospital. (The hospital was an acute facility not well suited to Anne's needs.) The move was made in due time, with Anne angry and acting out ("I'm mad! I'm mad! I want to go

back to the hospital!"), but there was no regression. She had special aides for six months, but gave them up without difficulty. She now acquired a biweekly tutor to help her with her educational deficiencies.

In March of 1977, Anne was moved to a smaller board-and-care home, along with other patients from the Clinic. Chess began to direct Anne to other people, telling her to ask them questions and talk with them. Anne began to have a social life at the home. Her controls were now better, and she made no attempt to be re-hospitalized. A few months later, she was moved to a still better board-and-care home, once again with other patients from the Clinic. On the first day, she told Chess: "I like it here." And she put her clothes away.

Anne no longer thinks it is normal to be crazy. She views critically the newly arrived patients who are still acting crazy and says they are "weird." She now feels guilty about having used other people, especially her mother, to control and confine her. She has brought her viola to the Clinic and now plays it there.

Anne continues to see Dr. Ross regularly, and she follows the Orthomolecular regimen which he prescribes.

Anne's HOD Tests

Anne has taken the HOD test four times. The first test was done November, 1975. Her score was 158. She took the test again October 24, 1976, shortly after moving out of the hospital into the board-and-care home. She was understandably anxious at that time, and her score was 219. After she settled in at the board-and-care home, she took the test again on December 15, 1976; her score was 111. On May 11, 1977, she took the test a fourth time; her score was 123. This time, Card No. 112 ("My family irritates me very much") was for the first time put in the "false" box. This coincided with friendlier behavior toward her family.

Anne's EWI Test

The first 200 items of the EWI test were administered to Anne in four brief sessions from August 4 through August 11,1977. The scores were then doubled to make up the profile. Anne enjoyed doing the test (as she enjoys the HOD test) and worked very hard at it, getting genuinely fatigued. Each time she showed fatigue, the test was put away and brought out again on another day. Anne asked about the words and sentences she did not understand.

Of the eight primary scales, none are in the normal range. This is not surprising, given the duration and severity of her illness, which has pervaded every aspect of her experience.

Her euphoria score is surprisingly elevated, yet she does not appear to be "high," or in any way speeded up. Looking around the room during group therapy, one can confirm that Anne is now the happiest of our patients. In the last few months, her face has taken on a kind of beatific look; she seems to be enjoying moments of inner harmony. Anne is the stuff of which saints and mystics are made—Jung would have said she was an introverted intuitive type. When Anne feels good about what might be called the state of her soul, this matters more to her than any external status or achievement.

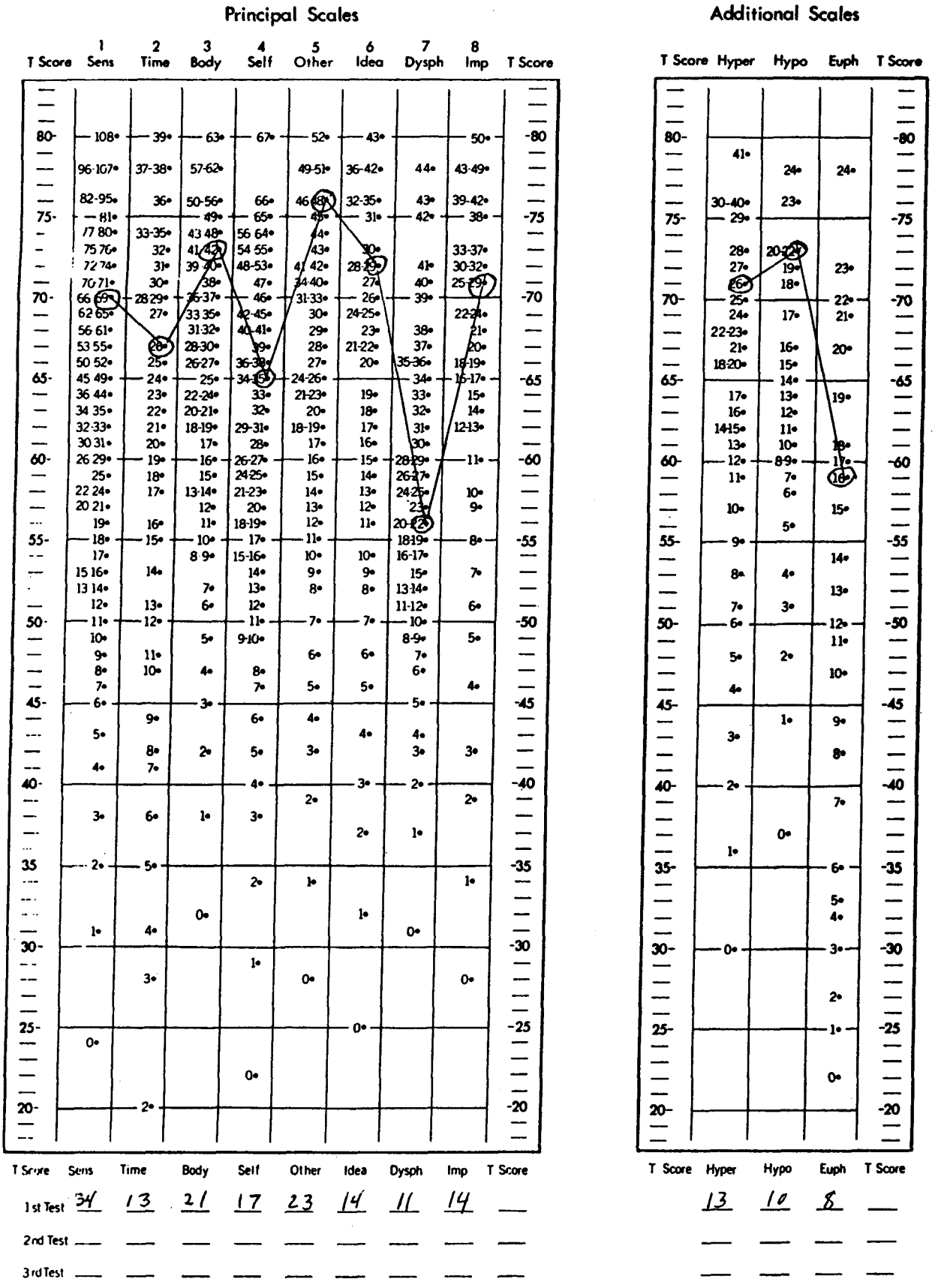
Dysphoria is the least high of her scores. She is much more often frightened or angry than depressed. We may expect relatively more depression if she improves enough to take on more problems in the outside world.

Anne's highest score is Perception of Others. Things have not really changed very much since the age of one when she was afraid of other children. The outside world—everything outside of the protection of her family and the Clinic—is menacing, ugly, horrible, cruel, and unpredictable. According to the test, Anne finds that people deceive her all the time, people act as if she were not there, people are muttering all the time, people smile strangely at her, people are parasites, people move and act as puppets do, etc. In addition to the direct dysperception of others, she now has accumulated a lifetime of unkind responses, however well-meaning, from people who did not understand her, were frightened of her, and could not help her.

Anne has many body perception symptoms: she feels that she is shrinking, that

FIGURE 1

FEMALE PROFILE



she is rotten inside, that her skin is sticky, that she is numb and turning to stone. In view of her history of self-mutilation, one wonders to what extent she experiences her body as belonging to her, or whether it is part of that outside world which gives her so little pleasure.

In the realm of ideation, Anne does not have any sense of control over what enters her mind. She cannot keep out frightening thoughts, and she gets little pleasure from thinking about things. She cannot be comforted with new ideas.

Anne is not as impulsive as she used to be. She does not answer true No. 140, "I have no will of my own." She still has murderous ideas and the urge to bite someone, but she now knows that she has some control over these impulses, but not yet enough to relax.

Anne has lived primarily in a timeless world, not knowing or caring what hour, day, season, or year it is. Past and future flood her in great waves, so that she may suddenly be angry and upset about "hitting the children," which, we find when we inquire, is a reference to her fellow kindergarten students, 20 years ago. She must then be reminded of the years that have passed, and she sinks back with relief and says, "Oh." Recently, she started to tell us again about hitting the children, but interrupted herself to say, "But that was a long time ago!" She may get upset about a future event, a forthcoming sailing trip with her family coming to a close too soon—she will have to hurry back. We ask, why? She does not have to come back at any particular time; she can stay out as long as she and her family desire. Again she sinks back with relief and says, "Oh."

Little children ask many questions about time: "How long is 'soon? " "When is it my birthday?" "Is tonight tomorrow?" "Why can't I have it now**?**" "When will I be five?" And so on. Anne's mother reports that Anne never asked questions about time. Only recently, for the first time, Anne asked her mother: "What day is today? Is it Saturday or Sunday?"

Very recently, Anne for the first time expressed boredom. During group therapy she said, very forcefully: "I am bored, Jack. I am bored!" Then, after considering what to do about this unusual feeling, she said: "I guess I'll go to the window and look out at the people." We would surmise that her growing awareness of time has at last made it possible for her to experience boredom.

Anne's self-perception is understandably very disturbed, as she has had a lifetime of failure at the tasks of socialization. However, she is now beginning to feel good about herself for varying periods of time. She is not yet accustomed to these good feelings, not at all sure she is allowed to have them, so she sometimes claims that she is "foolish," "dizzy," or "crazy," that she has performed badly, etc. We then gently remind her that she really did some task well, or that she really enjoyed herself on some occasion, and she accepts this and looks relieved.

Anne's improved self-perception is reflected in her growing interest in jewelry, clothing, and hair-styles. Her taste runs to diamonds, and she wants us to get her some earrings that are "24-carat gold!"

Anne still has a great many sensory dysperceptions, especially visual ones. Stairs look very steep, people and things look flat, and lines of print zigzag up and down. She reports that her eyes are overly sensitive to light, and that sunlight is dazzling. She sometimes puts her hand over her eyes, much less often now than formerly.

The EWI test provides a picture of Anne's illness which makes sense both to her physician and to her therapists. This is no small achievement, for Orthomolecular psychiatrist and therapist necessarily approach the illness from opposite poles. Each, in order to do his job, must attend to entirely different data. Yet they are talking about the same indivisible person. It is only our ignorance which makes it necessary to use such different words to describe Anne's biochemistry and Anne's perception of the world. Meanwhile, the EWI bridges the gap in our knowledge and tells us what Anne is up against in her struggle to get well. It tells us that Anne's illness has so pervaded her consciousness and distorted her development that only the most strenuous and determined intervention in her life can turn

the tide. It tells us that psychotherapy of an appropriate kind can be a valuable tool in the treatment of an Orthomolecular patient—even someone as seemingly unreachable as Anne.

Discussion

Like Helen Keller, Anne Sippi found herself trapped in a pattern of immoral and ungratifying behavior in response to a perceptual catastrophe. Anne Sullivan, Helen's teacher, realized that Helen's worst problem was **not** that she was deaf and blind, but that no one any longer expected her to behave like a human being. Her first move, accordingly, was to establish her moral authority with Helen and make it clear that she cared too much for Helen to allow her to behave like an animal. If this involved physical fights on the floor of the Keller dining room, so be it. Helen got the message and began to cooperate with the teacher who eventually freed her from her solitary existence.

Anne is getting the message, too, that we will not allow her to slip away into craziness. Having a schizophrenic illness does not require that one acts crazy, any more than being deaf and blind requires that one takes food from other people's plates. Direct confrontation therapy, like the "moral treatment" of the nineteenth century and like Anne Sullivan's method with Helen Keller, has as its premise that a person who is behaving in a crazy or subhuman fashion would like to stop doing that and rejoin the human race, but does not know how. It is the therapist's task to find ways of getting the crazy-acting person out of this bind.

We have been told that Anne is a "nuclear schizophrenic," that she is retarded, that "her synapses will never come together." We feel that the only proper use of diagnostic terms is to tell the person and his family what they are up against, where they can get help, what experts are available to them, what research js being done. Instead, many of the professionals who saw Anne labeled her, and the meaning of those labels was all too clear: you are a headache, get lost, we don't want you here, nothing can be done to help you. What we see is that Anne, at the Clinic named for her, has made a great deal of progress in the last three years, and we consider her potential for future growth unknown and unlimited.

Acknowledgements

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