ABSTRACT: The authors present the case of a schizophrenic man treated in the setting of a supportive care clinic. The course of treatment from beginning to termination is illustrated by treatment vignettes and by excerpts from the patient's letters to the therapists. Case discussion centers around the handling of the classic schizophrenic conflict over intimacy versus isolation. The authors stress that the therapists must be acutely sensitive to the patient's need and ability to regulate his or her own emotional and therapeutic distance over the course of treatment. They make a case for utilizing this conceptual framework in the treatment of chronic psychiatric patients in supportive clinic settings.

It is now generally accepted that major tranquilizers, while relatively effective against certain schizophrenic symptoms such as hallucinations, are of limited value in alleviating basic schizophrenic conflicts at the intrapsychic and interpersonal level. The latter issues are more likely to be resolved through various psychotherapy approaches. It has also become clear that individual psychotherapy is not available for all schizophrenic patients under the financial structure and resource availability of the current health care delivery system. In response to these facts, agencies committed to the treatment of schizophrenic patients have tried various modalities of treatment to offer the best treatment with their given resources. A common model has been the Supportive Care Clinic, a modality which employs a medication clinic in conjunction with formal or informal group therapy, as well as individual "discussions" between patients and therapists. This has raised interesting questions in respect to the optimal treatment of schizophrenic patients. One of the core conflicts which enters into the psychotherapy of schizophrenic patients is between the basic drive towards attachment and intimacy and the defenses against these. Such defenses originate from a relative lack of basic trust and from fears of annihilation, engulfment, and loss of ego boundaries. These issues have been discussed by other therapists (Jacob-
son, 1964, chap. 3; Tausk, 1919), since Otto Rank's (1952) original
description of "life fear" as a universal human conflict. The usual format
for working through this conflict has been individual psychotherapy. The
therapeutic handling of this conflict becomes more complex when treat-
ing patients in a supportive care setting. On the negative side, multiple
therapists dividing their attention among many patients can often cause
a diminution of any focalized transference which would allow insight and
resolution into the conflict. On the positive side, such a setting may offer
the patient a greater amount of control and autonomy in regulating his or
her own degree of distance while trying to understand needs for both
distance and attachment.

This article describes 2½ years of treatment of a schizophrenic
patient in a Supportive Care Clinic setting. The patient's use of the set-
ting, the therapists, and his writing of letters illustrates how his basic
conflict was partially resolved.

The Supportive Care Clinic at the University of Illinois Hospital
evolved as a medication group utilizing an informal group structure, with
three or four therapists from Social Work, Psychology and Psychiatry
(Winberg, Robinson, & Singer, 1972). The clinic has been deliberately
structured to allow patients a range of involvement and attachment with
therapists or other patients. In particular, efforts have been made to
avoid expectations of progress while remaining open to the drive and
capacity some patients may have towards progress. Patients in the clinic
are mostly chronic psychiatric patients, frequently those who have been
"failures" in individual or group psychotherapy. In addition, some
patients are referred to the clinic before other treatment modalities are
attempted, on the assumption that they may not currently be capable of
more intensive therapy.

Patients currently come to the Supportive Care Clinic whenever they
need prescription renewals, but may come as frequently as they want or
as we recommend. During their visits the patients may participate or
interact with staff or each other, assuming as much distance socially,
physically, and psychologically as each finds comfortable. The patient's
need to distance himself or herself is respected by staff and the patient is
subjected to minimal pressure to participate. Although engagement may
be encouraged or facilitated, group mores clearly endorse any level of use
of the program. Some patients tend to see their relationship with the
clinic and the institution at large as the major support system; other
patients are able to develop rather close individual relationships in the
clinic. Subgroups or cliques among patients and staff have also
developed over time. For some, obtaining their prescriptions and a cup of
coffee, perhaps sitting at the fringe for a few minutes, is the only
commitment they wish to make; from this posture they may progress to
closer contact with others or maintain this distance for years. The
possibility of a more intimate individual relationship with any of the