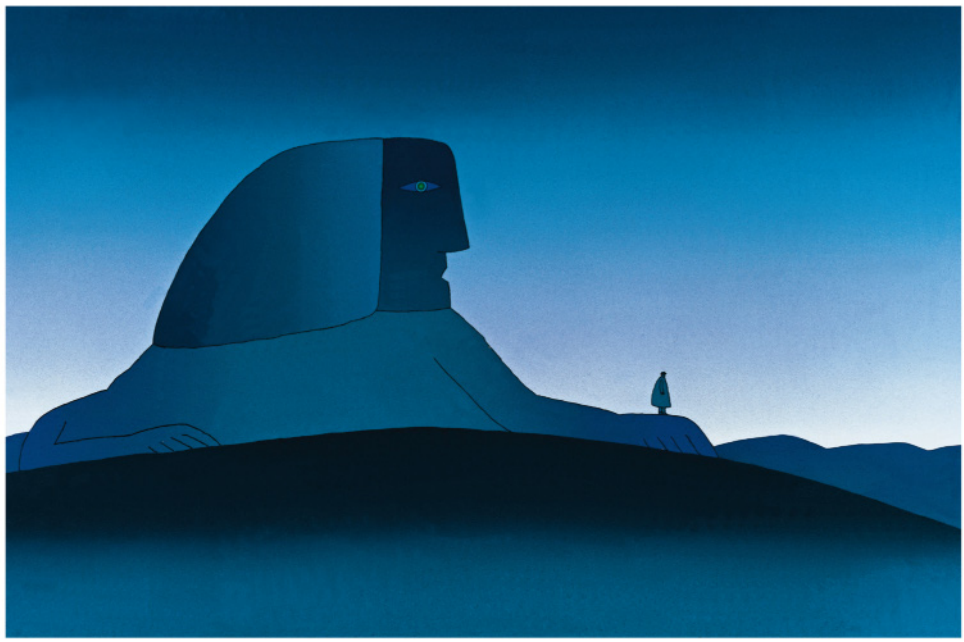
ANDREW LOTTERMAN

Psychotherapy for People Diagnosed with Schizophrenia

SPECIFIC TECHNIQUES



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ISPS THE INTERNATIONAL SOCIETY FOR PSYCHOLOGICAL AND SOCIAL APPROACHES TO PSYCHOSIS

ROUTLEDGE

PSYCHOTHERAPY FOR PEOPLE DIAGNOSED WITH SCHIZOPHRENIA

In this unique book, Andrew Lotterman describes a creative approach to the psychotherapy of people diagnosed with schizophrenia and other forms of psychosis. Lotterman focuses on specific techniques that can be used in psychological therapy with people who have symptoms such as hallucinations, delusions, paranoia, ideas of reference, looseness of association and pressured speech. Formerly titled *Specific Techniques for the Psychotherapy of Schizophrenic Patients*, this edition updates research on the biology and psychology of psychosis and explores the many controversial issues surrounding diagnosis. It also includes two new chapters on the psychology and treatment of paranoia and on the experience of having a shattered self and the delusion of being the Messiah.

Lotterman's innovative approach aims to help patients with one of the most debilitating symptoms of psychosis: the collapse of language use. By restoring language as a way of communicating the patient's meaningful inner life to himself and to others, the patient is then able to undertake a more traditional form of verbal psychotherapy. The book presents detailed case histories of patients who have benefited from this method, highlighting the specific techniques used and the psychological improvements that followed. The approach presented here complements medication-based treatments that have only had partial success, as well as other psychological approaches such as cognitive behavioural therapy, family therapy and social skills training.

Psychotherapy for People Diagnosed with Schizophrenia will be a valuable text for clinicians working with people suffering from psychosis, including psychotherapists, psychoanalysts, psychologists, physicians and social workers. It will also be of great interest to academics and students.

Andrew Lotterman, M.D., is a training and supervising psychoanalyst and associate clinical professor of psychiatry at Columbia University, USA. He has published widely on psychotherapy for psychosis.

The International Society for Psychological and Social Approaches to Psychosis Book Series

Series editors: *Alison Summers and Nigel Bunker*

The International Society for Psychological and Social Approaches to Psychosis (ISPS) has a history stretching back more than fifty years, during which it has witnessed the relentless pursuit of biological explanations for psychosis. The tide has been turning in recent years and there is a welcome international resurgence of interest in a range of psychological factors that have considerable explanatory power and therapeutic possibilities. Governments, professional groups, people with personal experience of psychosis and family members are increasingly expecting interventions that involve more talking and listening. Many now regard practitioners skilled in psychological therapies as an essential component of the care of people with psychosis.

ISPS is a global society. It aims to promote psychological and social approaches both to understanding and to treating psychosis. It also aims to bring together different perspectives on these issues. ISPS is composed of individuals, networks and institutional members from a wide range of backgrounds and is especially concerned that those with personal experience of psychosis and their family members are fully involved in our activities alongside practitioners and researchers, and that all benefit from this. Our members recognise the potential humanitarian and therapeutic potential of skilled psychological understanding and therapy in the field of psychosis and ISPS embraces a wide spectrum of approaches from psychodynamic, systemic, cognitive and arts therapies to need-adapted approaches, family and group therapies and residential therapeutic communities.

We are also most interested in establishing meaningful dialogue with those practitioners and researchers who are more familiar with biological-based approaches. There is increasing empirical evidence for the interaction of genes and biology with the emotional and social environment, and there are important examples of such interactions in the fields of trauma, attachment relationships in the family and in social settings and with professionals.

ISPS's activities include regular international and national conferences, newsletters and email discussion groups. Routledge has recognised the importance of our field in publishing both the book series and the ISPS journal: *Psychosis - Psychological, Social and Integrative Approaches*, with the two complementing one another. The book series started in 2004 and by 2012 had thirteen volumes with several more in preparation. A wide range of topics are covered and we hope this reflects some success in our aim of bringing together a rich range of perspectives.

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PSYCHOTHERAPY FOR PEOPLE DIAGNOSED WITH SCHIZOPHRENIA: SPECIFIC TECHNIQUES
Andrew Lotterman

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PSYCHOTHERAPY FOR PEOPLE DIAGNOSED WITH SCHIZOPHRENIA

Specific techniques

Andrew Lotterman

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FOREWORD

I still vividly remember my pleasure and excitement at coming across the first edition of this book by Andrew Lotterman back in 1996 (Lotterman, 1996).

At that time I was becoming more convinced of the potential for individual psychoanalytic therapy for some of the people I came across in the British NHS who had had psychotic experiences and breakdowns, including those who received the diagnostic label of schizophrenia. I had found that many of the authors I had read offered interesting and convincing ways of understanding psychotic phenomena from a psychoanalytic perspective. The literature was, however, almost devoid of assistance with discussion of particular psychoanalytic techniques that might assist me when faced with certain of those phenomena. An additional problem was that some people with psychosis related to me in a way that I was unfamiliar with in my work with people with non-psychotic disorders, ways that I found most disconcerting, such as very concrete paranoia or fragmentation of thought processes. Very few, if any, of the colleagues I worked with had experience of psychoanalytic therapy with those with ongoing psychotic problems. Certainly, my usual psychoanalytic psychotherapy approaches, especially using understanding in the form of interpretation, were neither indicated nor effective for some patients, particularly at those times when words had lost their usual usage as shared symbols for verbal communication of experience.

Hence the great importance to me of Andrew Lotterman's earlier edition with its detailed discussion of real-life therapy situations with the kind of psychotic phenomena that I was encountering. The book was so rich and useful to others too that I quickly learned that this was not a book to lend out, as I had to reorder copies for myself.

This second and greatly revised edition could not be published at a more opportune time. There is much greater concern now than for a long time about the limited effectiveness and acceptability of an approach to psychosis that has become far too exclusively biological and pharmacological in ideology and practice.

Fortunately, national guidelines for psychosis and schizophrenia are increasingly recommending psychological and family approaches. To its credit, the field of cognitive behavioural therapy for psychosis has been gathering evidence that overall it has a degree of effectiveness, and a volume in this ISPS series is devoted

to the best of contemporary practice. Recent studies are beginning to emerge demonstrating the effectiveness of psychodynamic approaches (Rosenbaum et al., 2012) but the pool of experienced practitioners is small in many countries. This book will therefore be a major support to contemporary practitioners who find themselves in the situation I was in some twenty-five years ago, excited by the possibilities of psychoanalytic work with people with psychosis but daunted by some of the here and now situations encountered.

Besides practitioners, there is an increasing hunger from many other people to better understand the psychoses from a psychological and social perspective. In the last decade, many have written of their own experiences of psychosis or their experiences as a family member, as well as the limitations and sometimes damaging effects of current mental health services. This book will be most helpful in providing a detailed and sophisticated way of understanding the psychological processes that result in many psychotic phenomena; it will make clear the human issues and experiences and feelings involved and circumvented in psychosis, as well as the importance of the early development of the mind and of disturbed experiences and the environment earlier in life.

This revised version includes a very rich and balanced discussion of the pros and cons of using the diagnostic label "schizophrenia". Andrew Lotterman has fully engaged with the increasing controversy around the term. For the purposes of this book, it has been essential that he makes it very clear that many of the patients he discusses in such rich detail have acquired that diagnostic label and sometimes have had it "confirmed" over many years. The importance of this is that if he had only used the broader word "psychosis", it might have been wrongly concluded that the therapeutic approaches delineated in this book are not applicable to those with the schizophrenia diagnosis (whatever one's views on the latter topic).

Having clearly conveyed and explicated his view that psychotic phenomena and aspects of mind are not on a continuum with the non-psychotic mind, but structured quite differently, Lotterman then provides an excellent chapter on how to create a potentially viable structure for a psychoanalytic psychotherapy with this group of patients. He tackles such issues as the setting and its potential disruption. He gives numerous examples such as that of the patient taking the therapist's books and journals as if he owned them himself. He addresses the need for purposeful structure in the rest of the patient's week. Throughout the book, the author is offering something that is far from a reductionist approach, and he is fully respectful of the need to work collaboratively with colleagues from other disciplines and the potential role of medication. His techniques are grounded in clear psychological theory, so that the reader can always understand why a particular approach is adopted. There is a modesty running throughout the book and there is no sense of excessive claims in terms of outcomes or that the psychoanalytic approach is necessarily the only one.

Each of the chapters of the book would serve as an excellent basis for multidisciplinary seminars and group learning. Indeed, Chapter 4 on *The psychological therapy of patients diagnosed with schizophrenia* would merit several discussions as it covers so many important areas, such as disturbed interpersonal relationships,

powerful affects expressed and avoided in psychosis, the very important and complex use of the countertransference feelings of the therapist, somatic experiences in psychosis and the loss of differentiation of self and other. Although these are distinct phenomena, the psychodynamic connections between these phenomena are clearly illustrated.

Later chapters take some of the particularly difficult themes and go into them in greater depth such as deadness, thought disorder, hallucinations and paranoia. Lotterman skilfully intertwines the psychological understanding of such themes with very practical ideas as to how to address the phenomena with the patient. A topic that is especially well discussed compared with other texts is one that is often a central topic in psychosis: the psychological issues involved with disturbances of thinking and use of language. Lotterman highlights key issues about the normal development of the use of symbols and language and the transformation of perceptions and sensations into thought and how these processes are reversed in psychosis (and in dreaming).

A hallmark of the psychoanalytic approach to psychosis is the understanding that many of the phenomena are attempts to minimise the experience of mental pain, whether this is an affect or a particular set of problems in intra or interpersonal relations or indeed the viability of the self. Lotterman is highly respectful of this in his vivid descriptions of the people he discusses, and one can often feel with him the never-ending balancing act in therapy in understanding the patient and his or her defences and at the same time working out when to support or encourage the patient to slowly manage more.

In a rich chapter that describes experiences of the shattered self, Lotterman quotes Fairbairn (1941) on the schizoid state: "He becomes afraid to love; and therefore he erects barriers between his objects and himself . . . all interest in the world around fades and everything becomes meaningless." Of course this is only one of the vital elements one often finds in psychotic states, alongside the fear of destructiveness of self and other, but I hope this gives a hint of the rich understanding to be found in this book and the much-needed very practical support and guidance given to practitioners and others in aiding the recovery of shattered lives.

Brian Martindale
Newcastle, UK. July 2015

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PREFACE

I want to say a few words about the methods I used in this book to disguise case material so that patients' privacy was preserved. Scientifically, it would have been ideal if I could present case material exactly as it was, using direct quotes from therapy sessions. But this was impossible given the need to preserve patients' anonymity. In presenting clinical illustrations, I chose to follow the method recommended by Clifft (Clifft, 1986). These recommendations are consistent with the suggestions of subsequent authors (Furlong, 1998; Gabbard, 2000; Kantrowitz, 2004). Clifft reviewed the recommendations of the American Psychiatric Association, the American Psychological Association and the World Psychiatric Association and developed guidelines for disguising case material. The goal is to communicate essential clinical data while preserving the patients' anonymity. Essentially, Clifft recommends changing basic information not essential to the clinical illustration, and avoiding use of specific identifying data and unnecessary detail. Transforming an external stressor from a death in a family to a divorce is an example of such a change in information. Similarly, a parent who has died may be described as being alive if this does not fundamentally alter the clinical sense of the material being presented. Of course, in a case where the psychodynamics revolve around a parental death, such a change should be avoided. If they do not change the essential clinical picture, false specific details may be added to disguise the patient's identity. Clifft also advocates changing specific details to more vague and general descriptions. If a patient grew up in Iowa, for example, one might describe him as being raised in the "Midwest". Gabbard (2000) suggested similar methods, and, in addition, the use of composites in which the features of several different patients are combined to illustrate a clinical point.

In the material I present, I make no change in what one might call the "category" of a symptom. By this, I mean that if a patient has an auditory hallucination, it remains an auditory hallucination. I do not transform it into a delusion, an idea of reference or a thought disorder. Nor do I change it into another kind of hallucination, other than auditory (e.g. tactile or visual).

Moreover, I preserve what one might call the character of the symptom. By this I mean that if an auditory hallucination is persecutory, it remains persecutory. I do not change it into a hallucination of support or command. Within a symptom with

a certain character, I may make changes in the content. For example, if a patient hears a voice telling him that his business competitors will lock him in a factory, I may disguise this by saying that the patient fears that the FBI will surround his home and prevent him from leaving.

In the clinical illustrations I discuss, I have used no direct quoted material from either patient or therapist. All of the conversations I report are paraphrased with changes made to specific words, phrases or idioms that might identify the speaker. Let us say, for example, that a patient associates a state of excited emotion with the conceptual image of "bursting" (as in "bursting with emotion"). The patient might sensationalize[1] the conceptual image of bursting in the form of feeling that his arms are expanding, and his skin is being stretched taut. In my report of this patient, I might change the conceptual image from "bursting" to "revved up", and I might report that the patient has the sensation that an engine is in his chest which is whirling around faster and faster, sending vibrations throughout his body.

Making such changes in the clinical material presented a challenge. I needed to alter the account of the patient enough so that anonymity was preserved, but not so much that what was essential or particular to the original case was lost. Moreover, the patient's affect, the fantasies connected to that affect and certain ideas or class concepts in the patient's mind have vital links with the subsequent hallucinations and somatic sensations. These links are crucial to understanding my ideas about deconceptualization, sensationalization and perceptualization. While I have needed to modify quotations, and the patients' use of distinctive and identifiable words and phrases, and have also had to modify aspects of the symptom picture, I have tried to make these changes in such a way that the salience and meaning of the verbal bridges between language use and symptom formation were preserved. This process took a good deal of time and work and I hope I have succeeded in preserving the sense and structure of these phenomena for the reader.

While the quotations are not exact, and some of the symptoms have been modified, I think the text presents a good overall picture of the clinical material that led me to develop my ideas about affect, thought, language, symptom formation and psychotherapy technique in work with psychotic patients.

I want to say a few words in this section about the debate that the editors and I have had about the use of the term "schizophrenia" in this book. The use of this term has become controversial in recent years and the editors and I had an ongoing exchange about this controversy.

Initially, I proposed using the term "schizophrenia" as one might any diagnostic label. I suggested that the title of this book be the same as the previous edition, which was published in 1996 under the title "Specific Techniques for the Psychotherapy of Schizophrenic Patients". The ISPS book series editors raised questions about the disputed nature of the term "schizophrenia"—for example, questions about its validity and the striking cultural differences in attitudes towards its use. As a result, I decided to revisit my understanding of the term and its impact on patients, clinicians and researchers. My decision to take another look at the diagnosis of "schizophrenia" was inspired also by the decision of the

Japanese Society of Psychology and Neurology and by the vote of ISPS members to remove the word "schizophrenia" from its title. John Read (*Models of Madness*, ISPS, Routledge, 2013, chapters 5 and 12) has written cogently about the problems with the scientific reliability and validity of the diagnosis "schizophrenia" and the way the term may exacerbate the stigma suffered by individuals with long-standing psychosis.

Some of what I will say here may be very familiar to some readers, so forgive me if I repeat what is already well known. My goal is to trace the steps in my own thinking.

In the beginning of the twentieth century Kraepelin (1902) and Bleuler (1911) developed somewhat different schemes about an enduring psychotic state that interfered with everyday social and vocational functioning. Kraepelin emphasized course as a marker of the illness and Bleuler the problems in the integration of the personality. Kraepelin distinguished schizophrenia from manic depressive illness, a distinction that has some significance for this book. Subsequently, a variety of diagnostic systems were developed designed to capture the characteristic features of a long-standing psychosis that, at least in some, led to a deterioration of personality and intellectual and social functioning (Feighner et al., 1972; Langfeldt, 1951, 1956; Schneider, 1959; Spitzer et al., 1978) and, finally, DSM III was published with its checklist of positive and negative symptoms. The developers of DSM III emphasized the poor reliability of earlier systems of diagnosis (which, it turns out, may or may not have been as bad as they described) and lauded the new DSM III for making substantial improvements. The view that DSM-III represented an improvement has been questioned by quite a few authors (see John Read, chapter 5 above; Kirk and Kutchins, 1994; Williams, Gibbon et al., 1992).

In the end, at this stage of understanding in our field (or lack of it), the question is whether using the diagnostic label "schizophrenia" is useful overall and useful in particular in the title and text of my book. Having struggled with this question now for quite a while, here is what I have come to: I think making diagnoses in working with individuals with different clinical presentations and symptoms can, in some cases, be very useful. To begin with: I think that the mind is organized in different ways in different individuals. I think it is useful to understand mental functioning as falling into several categories (which may have dimensional aspects): neurotic functioning, borderline functioning and psychotic functioning. Understanding the personality structure of the psychotic individual makes a difference in terms of therapeutic approach, both in terms of what the clinician may expect to occur during the course of treatment, the particular motives, conflicts and resistances that may present themselves in the patient, and the kinds of techniques one may want to use. When I treat an individual with borderline structure, for example, I am more on the lookout for high levels of aggression, an inconsistently functioning conscience, various forms of self-destructiveness, the incapacity to depend on another and the use of splitting and primitive projection than I would be in a neurotic patient. I might also assume that the subjective experience of emptiness, the emotion of futility and the experience of a dis-continuous

self-experience may be more prominent. All this alerts me to consider a universe of functioning that becomes more prominent in my way of thinking and sensitizes me to certain core problems of treatment. Of course, I may be wrong in my diagnostic impression, and so I need to avoid becoming fixed in my assessment. But the danger of being incorrect about the patient's psychic structure does not eliminate the potential benefits of organizing my thinking in this way.

I think similarly about my work with individuals diagnosed with schizophrenia. The chapter titled *The psychological therapy of patients diagnosed with schizophrenia* begins with an extensive section: "Psychic structure and the disturbances in ego function". I understand psychic structure in an individual diagnosed with schizophrenia to consist of disturbances in the capacity for emotional attachment, a disturbance in affect awareness and regulation, a disturbance in the formation of psychological boundaries, a disturbance in symbol use and a disturbance in the testing of reality. This way of diagnosing psychotic patients is structural and not descriptive. It guides both my understanding of the patient's material and my choice of a certain therapeutic approach, which differs from methods I might use with individuals who have neurotic or borderline mental organizations. These differing methods are described in the chapters on technique.

Apart from the "structural" diagnosis, I think that the descriptive diagnosis of schizophrenia serves some useful functions. For one, I want to be sure to make the point that I do not know if the techniques I present in this book will be particularly effective with individuals who have an affective psychosis. I have not worked psychologically in depth with large numbers of such patients and I don't claim to have special knowledge or skill in this area. I realize that there has been research demonstrating important overlaps between "schizophrenic" patients and "bipolar patients" in terms of phenomenology, genetic markers and treatment response. However, my own clinical experience is consistent with Kraepelin's original distinction between schizophrenia and affective psychoses: that in bipolar disorder there is a syndrome of psychotic symptoms characterized by rapid onset, affective symptoms, a circumscribed duration of psychosis and responsiveness to lithium and other mood stabilizers, after which the patient may return, more or less, to previous levels of function, which can be quite high. At least some, if not many (do we really know?), psychotic patients labelled "schizophrenic" do not fit this description and I think the distinction is worth making for assessment and treatment reasons. I appreciate that a hard and fast distinction between these two categories is not easy to make.

In addition to the diagnostic and treatment implications of using the term "schizophrenia", the use or non-use of the term "schizophrenia" may have an impact on our professional discussion with fellow clinicians and researchers. The majority of psychiatrists, other clinicians and researchers continue to use the term "schizophrenia" for patients with long-standing, non-affective psychoses. Despite the many controversies about this term, this is the term they use. There is much thoughtful and useful ongoing research about a condition that researchers and readers refer to as "schizophrenia". I would like this book to be part of

this ongoing discussion. I would not like it to be separated from the mainstream of research and clinical work by using a separate and vague term such as "psychosis" which might be confusing. Such a term might make it more difficult for researchers and clinicians in the field to communicate with one another about the main controversies we have (about reliability, about course, about validity), because we will now, overtly, be speaking two different languages ("psychosis" versus "schizophrenia"). When Harvey (1992) claims that "schizophrenics" have a measurable downhill course and that the diagnosis is highly stable over twenty years, and we respond that many "chronic psychotic individuals" do well over time, he may counter by saying that we are talking about two different groups, and that we have selected out those anomalous individuals who do not deteriorate and who are not "truly schizophrenic". What I think we want to do is to demonstrate that "true schizophrenics", so defined by the field in general, do not always deteriorate and support our argument with such studies as the Vermont Study (Harding et al., 1987) (which uses the term "schizophrenia"), with Gottdeiner's work (2002) (which uses the term "schizophrenia"), with Brian Kohler's work (which uses the term "schizophrenia") and many other excellent studies that use the term "schizophrenia" but challenge the biases that attach themselves to it.

In terms of our professional discussions, I would like to cite an example from a thought-provoking article by a neuroscientist, who believes that schizophrenia has a biological basis. Neal Swerdlow (2011) wrote an excellent article titled "Are we studying and treating schizophrenia correctly?" In it, he talked about the neural and molecular dysfunction found in many people with a diagnosis of schizophrenia, distributed in the cortico-striato-pallido-thalamic circuitry. He speculated that failures of early brain maturation become codified into dysfunctional neural circuitry. These lesions may reflect the operation of risk genes or epigenetic events. Despite his biologically based research, his treatment recommendation was surprising. It was that we should focus treatment on rehabilitative psychotherapies that can engage healthy neural systems to compensate for whatever biological vulnerabilities such patients may have, and he presented evidence of helpful neural changes that follow psychological interventions. Despite his being a neuroscientist interested in genes and neurons, he was very open to the potential benefits of psychological treatment. The use of the term "schizophrenia" did not prevent him from being open minded to the benefits of psychological treatment. I am concerned that if we use the vaguer term "psychosis" we will be cutting ourselves off from such creative colleagues as Swerdlow.

Thus, in avoiding the term "schizophrenia" I am concerned that we may be separating ourselves from the general psychiatric community. As much as I may disagree with the prognostic and therapeutic assumptions that some in this community make, I want colleagues to understand that the psychological approach I am proposing is for patients who many believe can only be helped by medication, and that these are the same "schizophrenic" individuals who some believe have a genetic "brain disease". I think the best strategy for changing the way the mental health community at large thinks about patients with chronic psychosis

that involves deterioration of the personality (in many cases) is to challenge the assumptions made about this group: that the condition invariably has a downhill course, that psychological therapy does not work and that it results only from neurochemical "imbalance" or genetic anomalies. Using the term "schizophrenia" enables us to challenge these assumptions directly, and to challenge the research that supports these assumptions. I am worried that in choosing not to use the term, we would lose this opportunity.

I am not sure that alternate terms for "schizophrenia" such as "psychosis" are good substitutes. The term "psychosis" is vague: it includes people with toxic psychoses, psychoses based on medical conditions, brief and reactive psychoses, psychoses that occur in connection with PTSD, etc. I do not think that it is helpful to group these conditions together, either for making a diagnosis or for planning a treatment. As I noted above, making a diagnosis can help guide a therapeutic approach. I would not, to give an obvious example, plan a psychotherapy treatment of a toxic drug-induced psychosis.

To expand on something I mentioned in passing above: one way to try to avoid the negative effects and stigma attached to the term "schizophrenia" is to cease using the term and to substitute another. However, I am concerned that this will not effectively eliminate bias or misinformation. Let's say we use the term "chronic psychosis". I suspect that the biases and prejudices that members of the field and public have towards individuals labelled "schizophrenic" (dangerous, other-than-human, untreatable, hopeless, etc) will simply become attached to the new term. Now, instead of "schizophrenics" posing a public health danger, "chronic psychotics" will. Instead of a tabloid reporting that a homeless man who has been diagnosed with schizophrenia has attacked someone, the homeless man will be described as a "chronic psychotic". In either case, the actual incidence of violence in this condition, and the dangers (real or imagined) that are involved, will take a back seat to the sensational headline.

Having said what I have about the potential benefits of retaining some use of the term "schizophrenia", I am mindful that the term has been used to label individuals and in some cases to make assumptions about whether it is a good idea to commit certain resources to their care (e.g. psychological treatment), what role medication should play in their lives and whether their futures are predetermined by their diagnosis. There is a great deal of evidence that these individuals can be harmed by misunderstanding and stigma and by the use of "schizophrenia" as a pejorative label.

Prior to publication, the series editors and I had an extensive discussion of our views about the term "schizophrenia". We finally agreed on an approach to using this term which hopefully represents a constructive resolution of our various views. We agreed to retain the word "schizophrenia" when we are discussing diagnosis, when we want to distinguish a form of chronic psychosis from affective psychosis and when we want to refer to psychiatric research about this condition. We agreed to retain the term also to indicate the continuity between the clinical material in this book and clinical conditions labelled "schizophrenia" in the general

psychiatric literature. Further, we agreed to put the term "schizophrenia" in quotes when we want to acknowledge that the diagnostic entity to which it refers is a controversial one—in regards to its claim to delimit a category of mental illness and its claim that this category is scientifically valid and reliable. The term "individual diagnosed with schizophrenia" and similar phrases used throughout the book represent an attempt to integrate these various considerations—to note that the individual has signs and symptoms consistent with what has historically been labelled "schizophrenia" but also that this diagnostic entity is a controversial one.

Note

1 By "sensationalize", I mean the process by which a concept is rendered into a bodily sensory experience. This process is described in Chapters 4, 5 and 6.

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1

INTRODUCTION

The roles of biology and psychology in people diagnosed with schizophrenia

The scope of the clinical problem

People given a diagnosis of schizophrenia often suffer from intense agony and loneliness. They may endure cruel emotional pain, and must bear up under tormenting feelings of humiliation, emptiness and despair. Efforts to understand and treat what is labelled "schizophrenia" have drawn from an array of medical specialties: neurology, neurobiology, biochemistry, radiology, physiology, genetics, epidemiology and infectious disease, not to mention psychiatry, learning theory and academic and psychodynamic psychology. Unfortunately, these have had limited clinical benefits, as I will outline below. The field of schizophrenia research is as fragmented as it is crowded. What complicates matters further is that there is probably no single entity of "schizophrenia" but rather a heterogenous group of conditions with varying etiologies and outcomes which are grouped under that term.

The emotional toll and social and economic costs of conditions called schizophrenia are enormous. For example, in the United States alone, it affects about 1.1% of the population, about 2.5 million Americans. The human cost is immense. Patients experience debilitating symptoms such as hallucinations, delusions, paranoid ideas, cognitive disorganization, social withdrawal, apathy and emotional flattening. The experience of self is often distorted. Patients feel themselves to be fragmented and helpless. Family and friends lose emotionally meaningful contact with psychotic loved ones and suffer along with the identified patient. Opportunities for emotional, creative and social fulfilment are shattered. The social and economic costs are also profound. As of 2002, in the US alone, the direct and indirect economic costs were estimated to be 62.7 billion dollars per year (McEvoy, 2007), and it is reasonable to assume that today that cost is much higher. Because people diagnosed with schizophrenia become ill when they are young, and can remain so for many years, the burden of illness is particularly severe. In the US approximately 12% of people diagnosed with schizophrenia are homeless, living in shelters or in prison. Another 16% are confined to chronic care hospitals or nursing homes (Torrey, 2006).

The purpose of this book

The reason for writing this book is to address a particular problem in the treatment of people diagnosed with schizophrenia. As I will outline, in recent times treatment has consisted mainly of biological interventions, mainly medication. As I will show, there is evidence that psychology can play an important role in both the etiology and the treatment of schizophrenic conditions. There is a group of people labelled schizophrenic who can benefit from the traditional forms of verbal psychodynamic psychotherapy (Rosenbaum et al., 2012; Pankey and Hayes, 2003). There is, however, another group of patients. These are patients who have symptoms of thought disorder, profound interpersonal deficits and poor self-object boundaries. They block out vast portions of their psychic life with primitive denial and projection, which in turn compromises their ego functioning. Their capacity to use words to describe their inner states is severely compromised. For this group, standard psychodynamic techniques may need to be modified to address the particular psychological structure of this form of psychosis, especially the disturbance in verbal function. Because standard psychotherapy depends on intact concept and language use, it is understandable that standard technique will break down in the face of disorders of thought and speech. A psychotherapy designed to address the particular psychotic psychological structure found in severe psychosis may be needed for these patients. The techniques described in this book are intended to describe this kind of psychotherapy.

The clinical limitations of medication

The foundation of treatment for schizophrenia in the last sixty years has been the use of antipsychotic medication. However, despite efforts to find effective treatments, the usefulness of antipsychotic drugs has been limited. Gutierrez (1997) reported that 20–30% of patients do not respond to these medications. Khan et al. (2001) found that there was less than 20% improvement in patients with positive symptoms when taking antipsychotic medication. Essock (1996) found that 48% of patients who were taking medication relapsed in the first year. Wunderinkk et al. (2013) found that dose reductions or discontinuation of antipsychotics during remission were actually associated with better long-term outcomes.

Certain symptoms are more likely to respond to antipsychotic medicine than others. Positive symptoms such as hallucinations, delusions and paranoid ideas are more likely to improve. However, negative symptoms such as social withdrawal, apathy, loss of motivation and emotional blunting remain uninfluenced by the use of medication. The Schizophrenia Patient Outcome Research Team study concluded: “There is no evidence that first or second generation anti-psychotics are effective for primary negative symptoms” (Lehman et al., 2004: 206). Moreover, even when antipsychotic medications are effective, patients stop taking their pills. Weiden (1997) found that 50% of patients had stopped medication after one year, and 75% after two years. The CATIE (Clinical Antipsychotic Trials for

Intervention Effectiveness) study (2005) reported that 64–82% of patients were not taking prescribed medication after one and a half years.

The problem of non-compliance leads us to a bit of a paradox. If we take the position that schizophrenia is a biological condition and that medication is the only effective treatment for psychosis, then we are faced with a dilemma. There is no medication that will induce a psychotic patient to take his medication if he refuses to take medication.

Accounting for medication non-compliance and incomplete efficacy, only 10–20% of patients are being effectively treated with medication at the end of two years. For 80–90% of our patients then, we must look for some kind of psychosocial approach to help them with their illness. In terms of adherence to psychopharmacological treatment, if it is indicated, a trusting emotional connection with a therapist can play a central role in the patient's choice to take medication.

Uncertain etiology hampers treatment

To effectively treat patients diagnosed with schizophrenia, it would greatly help to have some idea about what causes their problems. Unfortunately, there is no clearcut answer to this question. Whenever attention shifts to one etiologic focus, whether it is neuroanatomical, biochemical, neurodevelopmental, social or psychological, each new lead disappoints our hopes of finding a comprehensive cause. Each fresh discovery seems to apply only to *some* patients diagnosed with schizophrenia.

Uncertain diagnostic boundaries

Despite our attempts at understanding, the group of persons often given the diagnosis of schizophrenia remains confusingly heterogeneous. Over the years, we have tried to find that singular feature of the disorder that defines what is unique and characteristic of this group: premorbid functioning, age of onset, predisposing conditions, precipitating events, symptom clusters, duration of psychosis, cognitive and social impairment, neuroanatomical and neurophysiological markers, response to biological and psychological therapies, social and work functioning, and long-term outcome. No matter how narrow the criteria for diagnosis, and how rigorously we apply them, the response to therapy and the course of these patients' problems seem to defy reliable prediction (Hawk et al., 1975). We have great difficulty agreeing with one another about who we should diagnose as suffering from schizophrenia, and how we should treat them. This is discussed further in the next chapter.

A degree of consensus about the conditions labelled "schizophrenia"

Many researchers and clinicians believe that the condition we label "schizophrenia" actually represents a heterogeneous group of disorders with a variety

of etiologies and clinical presentations. Some of these conditions seem to spring from more biological dysfunctions, and some from environmental and psychological traumas.

Granting that there is probably no single unitary entity we can call "schizophrenia", there seem to be some basic observations concerning non-affective psychosis about which there is a degree of agreement among many recent researchers. Here is a selected list (some of the following is based on a paper by MacDonald and Schulz, 2009). In what follows, I will put the term "schizophrenia" in quotes to underscore the controversies concerning its status as a unitary, reliable and valid diagnostic entity.

1. "Schizophrenia" manifests itself in a variety of symptoms, none of which reliably define it. Patients may have a few or many of the following symptoms, grouped into two clusters: "positive" symptoms such as auditory hallucinations, visual hallucinations, delusions, paranoid ideas, disorganized speech and ideas of reference; and "negative" symptoms such as social withdrawal, apathy, flat or absent emotional responses and occupational or self-care difficulties.
2. The first symptoms of "schizophrenia" usually begin in late adolescence or early adulthood.
3. The vulnerability to "schizophrenia" seems to be at least partially heritable. The concordance rate for monozygotic twins is about 45% (Cannon et al., 1998).
4. Medications that reduce psychotic symptoms block dopamine D2-like receptors (among others) but these medications are not equally effective for all "schizophrenic" symptoms (Swerdlow, 2011).
5. There is evidence that certain gene regions are associated with the development of "schizophrenia" in some patients. (e.g. 8p and 22q, DISC1, Dysbindin, Neuregulin and G72) (Lewis et al., 2003; Badner and Gershon, 2002; Craddock et al., 2006; Papaleo and Weinberger, 2011). However, a direct link between "schizophrenia" and a specific gene or a constellation of genes has not been established.
6. Certain environmental, nonhereditary factors also increase the risk of "schizophrenia". These include: migrant status, age of the father, maternal exposure to famine during gestation, exposure to viral, bacterial and parasitic infection during gestation, maternal cannabis use, obstetrical problems and growing up in an urban environment. There is evidence from other research[1] that early childhood trauma may also play a role (Read and Ross, 2003) as well as early family environment (Tienari 1991) and trauma in adulthood (Hamner, 2000).
7. A variety of psychosocial treatments such as cognitive behavioural therapy, social skills training, family therapy and cognitive training have been found to be effective in reducing some symptoms (MacDonald and Schulz, 2009).
8. There are volumetric and/or morphometric abnormalities in multiple brain areas in some patients diagnosed with "schizophrenia" (Levitt et al., 2010).

The affected areas include the hippocampus, amygdala and anterior cingulate cortex (Boos et al., 2007; Pantelis et al., 2009; Ho and Magnotta, 2010). These abnormalities include the size or shapes of cells, numbers of neurons, neurotransmitter receptors, neural circuits and abnormalities of cellular proteins. However, these morphologic changes are found in some patients but not others. Moreover, it is not clear whether the symptoms of "schizophrenia" result from these "primary" lesions (e.g. the loss of a critical neural structure) or the "secondary" effects of these abnormalities on other areas of brain function. In addition, the same abnormalities have been found in relatives without a diagnosis of schizophrenia and others (e.g. those with a history of childhood trauma), so that while they may be associated with a *vulnerability* to "schizophrenia", they are not sufficient to cause the illness (Swerdlow, 2011; MacDonald and Schulz, 2009).

The role of environmental experience and trauma

In the last fifty years, the assumption has been that the major mental illnesses are caused primarily by biological factors. Recently, however, there is evidence that environmental factors can play a major role in symptom formation. There is a good deal of evidence that environmental stressors not only trigger genetic vulnerabilities, but are etiologic factors in themselves. For example, there is a strong link between a history of childhood sexual abuse and schizophrenia (Read, 2003). Of female inpatients with schizophrenia, 60% had a history of childhood sexual abuse (Read and Ross, 2003; Friedman and Harrison, 1984). Briere et al. (1997) found that childhood sexual abuse was "the most powerful predictor of later psychiatric symptoms and disorders". Women who had been sexually abused before the age of sixteen were 5.4 times more likely to be a psychiatric inpatient than those who had not. Women with a history of childhood sexual penetration were 16.8 times more likely to be psychiatric inpatients. Of children admitted to psychiatric hospitals, 77% of those who were sexually abused were psychotic versus 10% of those not abused (Livingston, 1987). While the consensus of psychiatric opinion has been that major mental illnesses are governed by biologically determined causes, and that their treatment therefore must have a biological basis, there is developing evidence that environmental influences can play a significant role in changing the course of illness.

Environment and brain interaction

The developing field of epigenetics studies the effects of environmental factors on gene expression. There is new evidence that environmental factors can profoundly influence the functioning of genes. Eisenberg (2004: 103) stated: "Genes set boundaries of the possible, environment parses out the actual." In 1998, Eric Kandel hypothesized that environment can change the brain by changing gene expression. He speculated that environmental factors alter the strength of synapses

between neurons, changing their function and even their structure. He wrote: "The regulation of gene expressions by social factors makes all bodily functions, including all functions of the brain, susceptible to social influences. . . . People who are not scientists think that genes are the ultimate controllers of behavior. What they don't realize is that the environment can alter the expression of genes and thereby modify the anatomical structure of the brain" (Barber, 2008: 194).

Koehler (2012) hypothesized that vulnerability to schizophrenia is linked to a cascade of interactions between genetic vulnerability and environmental experiences of stress, fear and trauma, social defeat and isolation, which in turn affect brain structure and function via hormonal and neural feedback pathways. A number of workers have written about the way in which "neuroplasticity" might mediate the effects of environmental factors on biological functioning (Doidge, 2007).

There is now evidence that the early family environment can influence the risk of developing psychotic illness. Studies have shown that the course of illness in biologically vulnerable children can be ameliorated by positive social experiences. Tienari (1991) reported a study in Finland in which children of parents diagnosed with schizophrenia were adopted and raised apart. The children who were studied were raised by families rated either as "healthy" or "disturbed". Five percent of those raised in healthy families became psychotic compared with 34% of those raised by disturbed families. Read and Ross (2003) commented: "data from the Danish adoption studies have consistently shown that being adopted out of a schizophrenic pedigrees at birth into a stable family reduces the risk of schizophrenia substantially."

"Schizophrenia" and post-traumatic stress disorder overlap

There is growing evidence that environmental stress can result in symptoms previously thought to be caused by biological factors. Positive symptoms such as hallucinations and delusions have been found in people given diagnoses of acute and chronic post-traumatic stress disorder (PTSD) (Butler, 1996). Capgras syndrome, in which the patient feels that friends and families are impostors, which is often associated with a diagnosis of schizophrenia, has also been found in people given a diagnosis of PTSD (Butler, 1996; Mester and Braun, 1986). Hamner (2000) compared patients diagnosed with schizophrenia with patients diagnosed with chronic PTSD on the Positive and Negative Symptom Scale (PANNS), a measure of positive and negative symptoms in schizophrenia. The group diagnosed with schizophrenia had only slightly higher scores on the positive symptom scale, and on the scale for global psychosis. Remarkably, on the negative symptom scale of the PANNS, the scores were identical. On the scale for general psychopathology, the two groups were also identical.

What can we make of the finding that negative symptoms can be associated with environmental stress? We are used to thinking that negative symptoms are characteristic, if not pathognomonic, of "*true* schizophrenia". However,

Andreasson (1982) has pointed out that negative symptoms are not restricted to the diagnosis of schizophrenia, and there is recent data to support this. Stampfer (1990) has identified an "avoidant symptom" component to PTSD characterized by avoidance of persons and places, feelings of detachment or estrangement, restricted affect and diminished interest in activities. Such patients show "functional decline, regressive personality change, 'autistic' withdrawal, preoccupation with odd ideas, variable dysphoria, autonomic/visceral dysfunction, general emotional constriction/flattening, despite intermittent lability crises, poor concentration, lack of motivation and loss of interest." Stampfer goes on to say that trauma can lead to a "withdrawal from gratification and work and social life". Seen in this light, negative symptoms may be a psychobiological response to persistent failure to master overwhelming trauma. Meyer et al. (1999) reported on the association between negative symptoms and trauma. Torture may also be associated with sequelae similar to negative symptoms. Doerr-Zeggers (1992) reported "impoverishment of psychic life, loss of capacity for work, inability to concentrate and emptiness and distrust of everything and everybody" following torture.

What about disorders of thought, also thought to be characteristic of the diagnosis of schizophrenia? Some thinking disturbances have been found to be caused by environmental stress. Ciccone (1989) found evidence of looseness of associations and illogical thinking in people diagnosed with PTSD. PTSD in children has been associated with decreases in three measures of reality testing (Haviland, 1995).

Thus there appears to be considerable overlap between PTSD and schizophrenia.

"Schizophrenia" as a final common pathway

The results from genetic, biochemical and environmental studies suggest that what we call schizophrenia does not result from one clearcut genetic or biological determinate. It is likely that psychosis represents a final common pathway for a variety of causal factors. This has been called the "stress-diathesis" or "vulnerability-stress" model and has been a focus of attention for about thirty years (Zubin and Spring, 1977; Zubin, 1980; McGlashan, 1986; Norman and Malla, 1993; Walker and DiForio, 1997). It is likely that schizophrenia is a generic name we give to a heterogenous group of disorders within an even broader group of disorders called psychoses. We can imagine a continuum in which some psychotic symptoms arise primarily from disorders of brain structure or function resulting from constitutional determinates, and some from psychological causes. Many expressions of psychosis may arise from the interaction of each of these.

The problem of using outcome to determine diagnosis

There is a knotty problem with the diagnosis of schizophrenia that complicates the biology versus psychology dilemma. Since the time of Kraepelin (1902) it has been widely assumed that schizophrenia is associated with an inevitable downhill

course. If a patient has a psychotic illness and gets progressively worse over time, then he is considered to have a schizophrenic disorder. On the other hand, if he improves, then perhaps he didn't all along; perhaps he has an affective disorder, for example. Similarly, if a patient improves with psychological treatment, some clinicians conclude that the patient is therefore not truly suffering from a schizophrenic disorder. This leads to a tautology. Diagnosis and prognosis become collapsed into one. However, our assumptions that schizophrenia is defined by its poor outcome are contradicted by research data. Harding (1987) reported that 50–60% of patients diagnosed with schizophrenia had improved at a twenty to twenty-five-year follow-up. These were patients whose illnesses had been severe. On average, they had been totally disabled for ten years, and continuously hospitalized for an average of six years. In Harding's study, 45% of patients previously diagnosed with schizophrenia no longer had psychiatric symptoms. Twenty-five to fifty percent of previously diagnosed patients had stopped their medications entirely and had no further symptoms of schizophrenia. A later study by Harding found similar results (Harding and Zahniser, 1994). Harding (1987) reported that "25-50% of patients diagnosed with schizophrenia were completely off their medications and suffered no further signs and symptoms of schizophrenia". Similarly, the World Health Organization (Harrison et al., 2001) reported that over 50% of patients in their study were doing relatively well as contributing members of their communities. Ciompi et al. (2010) summarized eleven studies reporting similar results (46–68% improved). Other studies (e.g. Ciompi, 1980, 1985) showed similar results: after thirty years, 25% of patients with schizophrenic diagnoses had completely recovered; 35% were much improved and relatively independent; 25% were improved but needed extensive support; and 15% were hospitalized.

Psychotherapy can change the brain

Not only is there evidence that non-specific environmental support can modify the onset and course of illness (Tienari, 1991), there is also data to show that more specific psychotherapeutic intervention can alter not only behaviour but also biochemical and molecular structures as well. Cognitive behavioural therapy, dialectical behaviour therapy, interpersonal therapy and psychodynamic therapy have all been shown to alter brain function in patients diagnosed with major depression, obsessive compulsive disorder, panic, social anxiety, post-traumatic stress and borderline personality. Two recent studies have shown that cellular molecular change occurs after psychodynamic psychotherapy (Lehto et al., 2008; Karlsson et al., 2010; Hirvonen et al., 2010). Swerdlow (2011) also cites evidence that psychotherapy can change cellular and molecular function (Baxter et al., 1992; Schwartz et al., 1996). There is also evidence that psychotherapy may affect brain regions distinct from those affected by medication (Beutel, 2010). It may be that cognitive behavioural therapy and

psychodynamic therapy, for example, act via effects on prefrontal control areas that influence limbic structures, rather than by acting on the limbic system directly.

A biological basis for psychotherapy in psychosis

Regardless of our ultimate understanding of the etiology of schizophrenia, we are faced with a therapeutic dilemma. Suppose genetic, constitutional or psychological events lay down the vulnerability for psychosis at a very early age. What does that mean for the treatment of this condition when its symptoms first appear eighteen years later in the young adult? There is no way to disentangle the multilayered neural and biochemical sequelae that result from the initial dysfunction over the complex course of later development. Our medications do not begin to be specific enough in terms of their effects on either neurochemistry or neuroanatomy to "target" these complex and multilayered processes. If modern neurochemical treatments have limited usefulness, how can we expect psychological therapy to play a role?

Swerdlow (2011) addressed this question in a very thoughtful paper. Even assuming, for the sake of discussion, that psychosis is always associated with brain abnormalities, this does not mean there is no role for psychological therapy. We know, he argues, that patients with stroke syndromes can be helped with cognitive interventions. Swerdlow argues that these treatments act by "engaging the normal psychological and anatomical properties of healthy brain circuits (e.g. in neighboring regions or parallel circuits) to restore or subsume the function of damaged ones" (Taub et al., 2002). Swerdlow notes that neuroimaging studies in schizophrenia show that despite the illness, many cortico-striato-pallido-thalamic circuits remain intact. Psychological therapies may act by stimulating the brain to develop compensatory functions in intact circuits. Psychological therapies provided in early life, or even later on, may help promote the health of compensatory brain circuits that may protect against the development of schizophrenic symptoms. Swerdlow writes: "Therapies that engender appropriate trust, and nurture areas of identified cognitive or emotional strengths (and their underlying limbic and frontal substrates), might be protective against pathological processes that would otherwise later lead to paranoia and social isolation" (2011: 6). As noted above, there is already evidence that psychotherapy can change the brain.

Given the diverse etiology of conditions labelled "schizophrenia" and given the extensive interactions between biological and psychological factors, it is important to be open to a wide range of treatments for this devastating condition. No doubt there will be continued progress in understanding the biological underpinnings of some of the conditions currently within the umbrella term "schizophrenia". However, there is already extensive evidence that psychological factors can play a pivotal role in the onset of psychosis and in its treatment as well (see below). The purpose of this book is to provide a set of psychotherapy techniques

that are useful for people with schizophrenic symptoms. These techniques are geared to address the particular psychological disturbances in this condition that often derail traditional verbal psychotherapy. In the next sections I will review the history of attempts at psychotherapy with patients diagnosed with schizophrenia, present new research concerning its usefulness and summarize the rationale for attempting this challenging form of treatment.

The history of psychotherapy for patients diagnosed with schizophrenia

Before 1952, with the introduction of chlorpromazine, there was little in the way of medication treatment specific for schizophrenia. Until that time, many patients diagnosed with schizophrenia were confined to hospitals or chronic care facilities and were treated sometimes more and sometimes less humanely. Relatively few psychiatrists were interested in the psychological treatment of those diagnosed with schizophrenia. Freud worked with some patients with psychotic or near-psychotic symptoms, but ultimately was pessimistic about the effectiveness of psychotherapy. He felt that it was difficult for patients diagnosed with schizophrenia to develop a workable transference neurosis. He wrote: "Observations show that sufferers from narcissistic neuroses have no capacity for transference or only insufficient residues of it. They reject the doctor, not with hostility but with indifference. For that reason, they cannot be influenced by him either; what he says leaves them cold, makes no impression on them; consequently the mechanism of cure which we carry through with other people cannot be operated with them" (1916–17: 447).

Despite Freud's pessimism, clinicians have persisted in trying to work with patients diagnosed with schizophrenia psychologically. These clinicians included Paul Federn (1952), Harry Stack Sullivan (1962) and his colleagues within the interpersonal tradition (Fromm-Reichmann, 1959), Semrad and Van Buskirk (1966, 1969), Will (1975) and the followers of Melanie Klein such as Segal (1950), Bion (1956, 1957, 1959), Rosenfeld (1965) and more recently Ogden (1982). A variety of workers within the ego psychology tradition also attempted psychotherapy with patients diagnosed as schizophrenic from a more classic standpoint (Arlow and Brenner, 1969; Boyer and Giovacchini, 1967).

Since the 1920s, there have been a number of individual case reports of improvement, and even dramatic cures, but it has been notoriously difficult to evaluate the role that psychological treatment played in their improvement. Until the advent of DSM-III (1980), there was no systematic way of making a diagnosis, so it was not clear whether the "schizophrenic" patients who improved with psychotherapy would be diagnosed as schizophrenic according to today's standards. In addition, there have been very few well-designed controlled studies of psychotherapy with patients with the "schizophrenic" diagnosis. (I will discuss some of these shortly.) With the advent of the widespread use of antipsychotic medication and the uncertain results of psychotherapy, the diagnostic entity "schizophrenia"

came to be seen increasingly as a biological illness that required an exclusively biological treatment. At its best, psychotherapy is a labor-intensive procedure, involving a highly personalized treatment plan that effects changes taking many years. It is a difficult skill for clinicians to master and usually involves periods of demoralizing setbacks that not only test the psychotherapist's skill but also his patience, persistence and self-confidence.

In the United States, by the mid-1970s, interest in the psychological treatment of schizophrenia had waned and the weight of psychiatric opinion had turned against it. The high cost of psychotherapy with psychotic patients, in both time and expense, combined with the absence of clear outcome data establishing its usefulness led some writers to question its efficacy. Some authors went so far as to assert that psychotherapy with patients diagnosed with schizophrenia is actually harmful (Drake and Sederer, 1986). This belief became rather widespread in the American psychiatric literature. In 1997, in its guidelines for the treatment of schizophrenia, the American Psychiatric Association (1997) stated: "Intensive exploratory techniques during the acute phase of psychosis can prolong disorganization and precipitate relapse." In 1998, the Schizophrenia Patient Outcomes Research Team (PORT) sponsored by the National Institute of Mental Health asserted that: "Psychotherapy that promotes regression and psychotic transference can be harmful to persons with schizophrenia. This risk, combined with the high cost and lack of evidence of any benefit, argues strongly against the use of psychoanalytic therapy."

These recommendations against the use of psychotherapy were regrettable given that they were not based on any empirical evidence, and that there is no documented case of psychotherapy harming a patient diagnosed with schizophrenia. The prevailing bias against the use of psychotherapy was drawn from a very small number of clinical reports that became highly influential. These reports were poorly designed, based on opinion rather than clinical data and in some cases were derived from anecdotal accounts (or even hearsay). In 1986, Drake and Sederer presented a single case report of a story told by a patient's family of a five-time-per-week psychotherapy conducted years earlier. It was not clear what the nature of this psychotherapy was, nor its duration or methods. At some point, "in the context of" the psychotherapy, the patient became delusional. In a separate, later hospitalization, while participating in group therapy (not individual therapy), he became agitated in the group and "attacked" (it is not clear if this was a physical or verbal attack) group members. Drake and Sederer used this anecdotal report along with an older study by Fairweather et al. (1960) (which showed equivocal results and which had methodological flaws) to arrive at their conclusion: psychotherapy is harmful to patients diagnosed with schizophrenia. They used the analogy of pouring hot oil on a wound, a discredited medical practice. The power of their argument lay more in the evocativeness of their metaphor than the clinical data they presented.

Drake and Sederer's paper had a significant impact on a 1990 editorial by Meuser and Bernbaum that reviewed a variety of studies of psychotherapy

with patients given the diagnosis of schizophrenia. Meuser and Bernbaum recommended a "moratorium" on psychotherapy with patients diagnosed with schizophrenia. In 1995, Scott and Dixon wrote a paper concluding that psychotherapy could be "toxic" to psychotic patients. As evidence, they cited the editorial by Meuser and Bernbaum, which in turn cited Drake and Sederer. Scott and Dixon thus, via a chain of repetition, used the evidence presented by Drake and Sederer, which consisted of one anecdotal case and the methodologically problematic Fairweather report. None of the authors mentioned above themselves conducted research on patients diagnosed with schizophrenia, and there has been no documented case of psychotherapy causing harm to a psychotic patient. Nevertheless, the conclusions came to be cited and repeated in the literature, and contributed to the widespread bias against the use of psychotherapy with psychotic patients. This bias ultimately became the basis for the warning against the use of psychotherapy in the National Institute of Mental Health PORT recommendations and the Guidelines of the American Psychiatric Association.

In contrast, both individual clinical reports and more recent research studies (Rosenbaum, 2012; NICE, 2014; Gottdeiner, 2002; Garrett and Turkington, 2011; Wright et al., 2009) suggest that psychological therapy has helped many psychotic patients to reduce or tolerate their symptoms enough to function socially and remain employed. These studies also show that psychotherapy can help patients forge alliances with prescribers so that they continue to take medication when indicated, and to understand their emotions (e.g. hatred, aggression or fear) so that they can be less self-punishing and more self-accepting (e.g. Saks, 2007). It is therefore unfortunate that the bias against the use of psychotherapy in the United States has become so entrenched. It has resulted in psychotherapy being withheld from patients, often leaving them to suffer alone with their frightening fantasies and emotions and to have no setting in which they can unburden themselves of their terrifying fears. Even if listening to patients only serves the purpose of helping them feel less alone, less bizarre and less non-human, it serves a worthy function.

In contrast to the United States, in other areas of the world, notably Northern Europe, the support for the psychological treatment of non-affective psychoses accelerated in the 1970s. Alanen et al. (1991) and Rakkolainen et al. (1991) introduced the use of need-adapted treatment in the public health system in Finland. This form of psychotherapy as well as a modification of it, the open dialogue approach, includes individual psychotherapy, family therapy and limited medication use. Several studies have shown it to be very effective in treating psychosis and perhaps in early psychosis prevention as well (Aaltonen et al., 2011; Seikkula et al., 2011). In addition, there has been increasing interest in the use of cognitive behavioural therapy for severe mental illness. A variety of studies have shown it to be effective (Sensky et al., 2000; Turkington et al., 2006; Morrison, 1994; NICE, 2014).

One final point: work with psychotic patients can be very difficult and painful for the therapist. The more severely ill the patient, the more the countertransference

reflects the emotional turmoil in the patient. As a result, in the psychotherapy of schizophrenic patients, the experience of the therapist can be unusually painful and confusing. While there are many reasons why the psychiatric community has come to recommend against psychotherapy with psychotic patients, I believe that the anguish that accompanies this work may play an important part.

A summary of the rationale for psychotherapy for people diagnosed with schizophrenia

Psychotherapy can be a legitimate and sometimes essential part of the treatment of a psychotic patient. The goals of psychotherapy may range from the modest to the ambitious. One may conduct psychotherapy to strengthen a therapeutic alliance and increase the chance that a patient will follow his pharmacological treatment plan. Alternatively, one may focus on non-psychotic aspects of personality function to strengthen real-world adaptations and reduce functional deficits. Yet another focus is the interpersonal and psychological meaning of the patient's psychosis. This approach presumes that psychological conflict and pathological defences may contribute to psychotic symptoms, and can be modified with psychotherapy.

Psychodynamic psychotherapy can be helpful for several different reasons. First, accurate interpretations help bring disruptive unconscious affects and fantasies to the surface, and this may reduce their disruptive effects. Second, accurate interpretations may be experienced as a sign of the therapist's attentiveness and personal care, which leads the patient to feel accepted. When a patient feels understood by another person, he feels less like a machine, less like a monster, less alone and more human. Because the interpersonal world of psychotic patients is often more eccentric and isolated than neurotic patients, the crucial experience of feeling significant and understood may not exist outside the therapy. Withholding psychotherapy is not a neutral step. It can deprive a patient of much-needed emotional contact. Research demonstrates that patients value being listened to (Duckworth et al., 1997). Moreover, menacing fantasies and emotions will not simply disappear if the patient avoids psychotherapy. It is naive to assume that it is psychotherapy that introduces terrifying images into the patient's life. Withholding psychotherapy will not make the patient's inner chaos go away.

There is a group of patients with psychotic symptoms who can make use of more or less conventional psychodynamic psychotherapy. These are patients whose thinking, speech and behaviour have not been overly distorted by psychosis, and who have not become so suspicious that they reject the possibility of a psychotherapeutic relationship. Standard psychotherapy can address these patients' problems with social relationships, self-esteem, sexual inhibitions and conflicts about anger. It can link the patient's interpersonal conflicts together with his character conflicts and both, in turn, with his symptoms. It can also address the patient's struggle over using the medication that he has been prescribed.

There is, however, another group of patients. These are patients whose psychosis has altered the way the mind functions. These are patients whose psychosis has interfered with the way impulses, emotions and verbal concepts are organized, and this interference has compromised their ability to make use of language as a medium of communication. For these patients, traditional psychotherapy, which depends so much on the use of words, breaks down. Language-based ideas no longer reliably convey subjective experience. These patients require an approach that is different from the traditional one. It is this alternative approach that I outline in the rest of this book.

The effectiveness of psychotherapy with these patients should by no means be taken for granted. Psychotic patients are very difficult to work with, and many are no better after the sincere and dedicated attempts by clinicians to help. There are many reasons for this, some having to do with the role of biological factors in a particular patient, the damage done by the illness to thinking, feeling and social relatedness in a particular case, the limitations of psychotherapy methods, or the poor match between patient and therapist. For many patients, however, psychotherapy can help symptoms to become less severe, and adaptation to work and social life improve, sometimes markedly.

This book is an attempt to help make room for psychotherapy as a modern treatment approach to psychotic patients. I am not suggesting that every psychotic patient be treated with psychotherapy, nor that it should be the treatment of choice for every willing patient. Unfortunately, at this stage we do not know how to identify in advance which patients can benefit from psychological treatment and which will not. So, at this point, we must proceed carefully. Perhaps with more experience and innovations in technique, more patients will become suitable for this kind of work. Even if a modest number of patients can reclaim a portion of their emotional and social lives by means of intensive and personal contact, it is a practice that is worth encouraging.

Note

1 This research is not included in MacDonald and Schulz's 2009 paper.

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2
DIAGNOSIS

Diagnosis and its complexity

Ideally, making the diagnosis of a problem helps us understand it and resolve it. This is so whether the problem is a biological one (e.g. shortness of breath), a diplomatic one (e.g. a trade imbalance that raises international tensions) or an experience of mental anguish. Diagnoses are used routinely in medicine to identify the causes of symptoms of physical illness and to develop a plan for treatment.

Arriving at a diagnosis can sometimes be straightforward: an x-ray or MRI may clearly establish what the problem is, a prognosis can be assessed and a pragmatic treatment plan can be developed. However, even in medicine, making a diagnosis can be quite complicated, as, for example, when tests produce contradictory results, or when symptoms are obscure and equivocal. Diagnostic procedures, even the ones most commonly in use, can fail to produce a reliable and accurate picture of what is going on. For example, in one study, when coronary angiograms were assessed by radiologists, the level of agreement between them when reading the same film was midway between 0% (chance) and 100% (perfect agreement) (Detre et al., 1975).

If making a diagnosis for medical conditions is difficult, making a diagnosis for psychiatric problems is vastly more so. For most conditions, we do not know what is the mixture of neurobiological and psychological factors that contribute to the difficulty. In the psychoses, our understanding at this stage is, at best, only limited. The interactions between psychological factors and biological causes are extensive, extraordinarily complex and difficult to sort out. Molecules (neurobiology) move mind, but it is also true that mind moves molecules.

The psychiatric diagnosis of schizophrenia

There are perhaps no aspects of the condition labelled "schizophrenia" that are more fraught and more controversial than the reliability and validity of the diagnosis itself. A comprehensive discussion of the history of the concept and the debate about this diagnostic label are beyond the scope of this chapter. I will, however, discuss a few highlights of this very complex debate about how we

identify "patients" for "treatment" and what some of the implications of our methods are.

Controversy has surrounded the descriptive diagnosis of schizophrenia since the time of Kraepelin. Most contemporary authors agree that the term "schizophrenia" denotes not one uniform entity, but a group of perhaps related conditions in which symptoms may be mild or severe, remitting or chronic, early or relatively late occurring, quietly devastating or floridly dramatic. The term has experienced a considerable evolution in descriptive psychiatry.

Defining schizophrenia by cross-sectional symptoms or by course of illness

Modern descriptive diagnosis in mental disturbances began with Kraepelin (1902)[1] who developed the concept of the "dementia praecox" to distinguish the disorder from manic-depressive illness. He believed that the illness had an early onset and progressed inexorably on a downhill course to dementia. Symptoms included hallucinations, delusions, withdrawal, poor judgement, difficulty with concentration and attention, and disconnection between ideas and affect. Kraepelin's diagnosis relied heavily on the course or outcome of the disease: if a patient did not have a deteriorating course, most likely he did not have schizophrenia.

Eugene Bleuler (1911) characterized what he termed "the schizophrenias" not by course, but by cross-sectional symptoms and the dysfunction of the mind associated with them. His "fundamental" symptoms included: association (disturbed), affect (disturbed), autism and ambivalence. Hallucinations and delusions were thought to arise secondarily from the fundamental symptoms. Bleuler believed that there were probably a variety of dysfunctions that could produce the symptoms he described, and concluded that what he called "the schizophrenias" represented a group of disorders, not one homogeneous entity.

Schneider (1959) also rejected the idea of defining schizophrenia by its course. He developed another list of cross-sectional symptoms that he termed "first rank". These included such phenomena as auditory hallucinations in which voices comment on one's actions or argue, thought withdrawal, thought insertion and delusions of control or passivity. In an effort to define this group of patients, Carpenter et al. (1973) developed another symptom list that included restricted affect, incoherent speech, nihilism and delusions.

A problem with many of the cross-sectional approaches, however, has been their lack of specificity and poor correlation with outcome.

Feighner et al. (1972) combined a list of cross-sectional symptoms with a time span for duration and onset. What were called the Research Diagnostic Criteria drew from Feighner and Schneider's work and ultimately became the basis for diagnosing schizophrenia in DSM-III (APA, 1980). The presence of some combination of delusions, hallucinations, thought disorder, flat or inappropriate affect and deteriorated work or social functioning defines the illness. There is a six-month duration criterion for inclusion. Thus, the course of the disorder is included

along with cross-sectional symptoms in developing the diagnosis. The diagnostic criteria for diagnosing schizophrenia developed in DSM-III have been essentially preserved in the later versions, DSM-IV, DSM-IV TR (2000) and DSM-V (APA, 2012).

DSM-III recognized "spectrum" or dimensional features of schizophrenia. Those who have the disorder for less than six months were labelled "schizophreniform", and those who do not quite meet the full diagnostic criteria were termed "schizotypal". One problem with diagnostic criteria that include course is that they are tautological. Ninan writes, "However, when the course of illness itself is part of the diagnostic criteria (i.e., symptoms present for at least six months in the DSM-III criteria) such arguments become inherently circular in nature, and are of limited value" (1990: 2). This becomes important in evaluating psychotherapy technique and outcome. If one finds that schizophrenic symptoms seem to improve with psychotherapy, one may be faced with the objection that the patient did not, after all, have schizophrenia. Even if such a patient meets all the cross-sectional criteria, as well as the criterion of six-month duration, the traditional association between downhill course and diagnosis is strong in the minds of many. That such a patient could improve with psychotherapy meets with considerable scepticism.

The purpose of DSM-III was to operationalize terms and to classify overt and *objective* behaviour to develop valid and reliable criteria for research use. It was hoped that this would reduce confusion in research and treatment efforts.

Some problems with the current diagnostic criteria for schizophrenia: reliability, validity outcome and the boundary with affective psychosis

While the DSM (and the ICD 10) became the de facto authority on what constitutes "schizophrenia", there is controversy about how reliable and valid its diagnostic criteria are. Kirk and Kutchins (1994) made a detailed study of kappa values (a measure of reliability) and found them low or undependable. They also found that much of the data supporting the reliability of DSM-III was poor.

Beyond this, many writers have argued that it is difficult to claim "validity" for a diagnostic concept when the methods used to identify subjects are not reliable. Pull, for example, argues that "reliability can be high while validity remains trivial" (2002: 23). The problem of unreliable and invalid diagnosis was famously highlighted by the experiment of Rosenhan, conducted in 1973 and reported in the journal *Science*. "Pseudopatients" (that is, "normal" individuals who were not psychotic) were admitted to various inpatient hospitals. They simulated auditory hallucinations. After admission, all the patients stopped reporting psychosis and displayed no symptoms. They informed hospital staff that they felt well. With the exception of one, all were diagnosed with schizophrenia and were urged to acknowledge having an illness and to take medication as a condition of discharge. In a second complementary study, Rosenhan told a hospital that he would be sending "pseudopatients" for admission. Following this, forty-one were identified as

high-probability pseudopatients by at least one staff member. Twenty-three were suspected to be pseudopatients by at least one psychiatrist. Nineteen were thought to be faking by one psychiatrist and one staff member. In fact, Rosenhan had sent no pseudopatients to the hospital at all.

Another problem in making the diagnosis of schizophrenia is the question of which criteria are used. According to Jansson and Parnas (2007), since the concept of schizophrenia was introduced, there have been forty or more different definitions of the term. Criteria used for making the diagnosis have ranged from the presence of psychotic symptoms (e.g. hallucinations and delusions), disordered self experience or subjective orientation (Bleuler, 1911), compromised unity of consciousness and self-dissolution (Kraepelin, 1919), a downhill course (Kraepelin, 1919; Feighner, 1972), social and occupational dysfunction, disorganized thought, affect or behaviour, and a dulling of emotions or motivation, as well as a variety of hypothesized underlying neuroanatomic, neurophysiologic or genetic biological dysfunctions. Each of these diagnostic criteria raises complex problems of their own. As I noted, in making a (deteriorating) course part of the diagnostic criteria for schizophrenia, researchers may be creating a tautology. If a patient with psychosis improves, he is removed from the sample of "schizophrenic" patients and thus skews the outcome of research results. There has been great controversy about this criterion over the past 100 years.

As described above, Kraepelin's original concept of dementia praecox included deterioration over time as an essential aspect of the diagnosis. Bleuler's (1911) did not. He wrote, "It is impossible to describe all the variations which the course of schizophrenia may take" (1911: 328). The data on how well patients diagnosed with schizophrenia do over time is extremely variable. As Read (2013) points out, studies over the last century find "massive variations in outcome". Some of these studies conclude that very few patients diagnosed with schizophrenia recover: from 13% in Stephens et al.'s (1997) study to 30% in Bleuler's research (1972) and 30% in Ciompi's work (1980). Others have found recovery to be much more frequent. Harding (1987) reported that at a follow-up thirty-two years later, in a sample of patients with severe psychopathology, 82% had not been in a hospital in the last twelve months, 68% had few or no symptoms and 40% were employed. The World Health Organization (2001) reported that the average recovery rate at fifteen or twenty-five years was 48%. Ciompi came to the conclusion: "There is no such thing as a specific course for schizophrenia. Doubtless, the potential for improvement of schizophrenia has for a long time been grossly under-estimated" (1980: 420). Jobe and Harrow (2010) came to a similar conclusion: "There is overwhelming evidence that very few patients with schizophrenia show a progressive downhill course."

Complicating these diagnostic issues further are the profound social and treatment implications that making a diagnosis of schizophrenia can have. The diagnosis can carry powerful social stigma (Schulze and Angermeyer, 2003). Identified patients often internalize the negative view of others (Dinos et al.,

2004). Patients labelled "schizophrenic" are often perceived as: dangerous (Angermeyer et al., 2004a), unpredictable (Angermeyer, 2005), irresponsible (Penn and Nowlin-Drummond, 2001) and dependent (Angermeyer et al., 2004b; Angermeyer and Matschinger, 2005). (See an excellent discussion of this in Read and Dillon, 2013.)

Beyond this, labelling a person schizophrenic often dictates the nature of the treatment they will receive. For many psychiatrists, the diagnosis of schizophrenia suggests that the etiology of the patient's symptoms is biological and requires a primarily biological treatment (i.e. medication). In the United States few psychiatrists hold the belief that psychological and environmental factors can play a significant role in the disorder, and so psychological interventions are often not seriously considered. The patient may be steered away from helpful psychosocial treatments because they are considered superfluous.

In addition, attaching the label "schizophrenia" to severely ill patients may accelerate the patient's alienation from family, friends and community, which in turn may further increase their stress and experience of "otherness". Patients during the early phase of psychosis may be particularly vulnerable to abandonments and the breakdown of social supports, which further exacerbate their illness.

One legacy of the Kraepelinian tradition is the distinction between schizophrenic psychosis and affective psychosis. For Kraepelin, these conditions are clearly distinct. Affective psychoses, while sometimes florid and dramatic in terms of symptoms, can potentially resolve and the individual can return to his pre-morbid psychosocial functioning. The functioning of these patients does not deteriorate over time. There are many examples of well-known scientists, politicians and artists who functioned at very high levels despite severe depression or bipolar disorder. In recent years, the hard and fast distinction between "schizophrenic" psychosis and affective psychosis has been questioned. Evidence suggests that patients diagnosed with schizophrenia often have a clinically significant affective component to their illness. In addition, there is now evidence that "schizophrenic" psychoses and affective psychoses share common neuropathological and genetic elements (Walker et al., 2002; Cardino et al., 2002). Cardino et al. (2002) wrote: "Much of the evidence points to a significant overlap and commonality of genetic heritage between schizophrenia and bipolar disorder."

Personally, I find the distinction between affective psychoses and the psychosis associated with a diagnosis of schizophrenia to be helpful. At the extremes, on the one hand there does seem to be a psychosis associated with intense changes in mood and emotion, which despite its severity can completely resolve. On the other, there are some psychoses in which the unity of consciousness and the disorder of self experience is prominent, which seem to be associated with a deterioration of personality functioning. However, having said that, I think it is premature to draw very many diagnostic, prognostic or treatment-planning conclusions from this coarse and imprecise distinction.

The psychodynamic approach to defining psychosis based on the organization of the mind

It should be noted that, whatever their benefits may be, the methods of psychiatric diagnosis described above do not address what goes on psychologically in the minds of patients diagnosed with schizophrenia. Thus, they tell us little about how to develop psychotherapy technique. For example, they do not differentiate between a formerly "schizophrenic" patient who no longer meets DSM criteria and a patient with a character disorder. Yet the psychological functioning of the once overtly psychotic patient may be very different from the patient with personality disorder. In the formerly psychotic patient, defences may be more primitive, fantasies more distorted, self-object boundaries more porous, emotional life more empty, symbol use more disturbed, relatedness more fragile and the more subtle aspects of reality testing more compromised. To make these distinctions, which are more directly relevant in guiding psychotherapy practice, one needs to make a psychodynamic diagnosis.

A history of the psychodynamic diagnosis of psychosis

With some exceptions (e.g. Kernberg, 1970), psychoanalysis, the driving force behind most psychodynamic psychotherapy, has not been systematic in classifying the patients it treats. The same may be said of the many clinicians who have worked with patients considered schizophrenic in psychotherapy.

From a clinical standpoint, early workers in this area (Fromm-Reichmann, 1959; Sullivan, 1962; Searles, 1962; Bion, 1957) did not concern themselves much with diagnostic issues. These authors provided clinical descriptions of symptoms such as hallucinations, delusions, social anxiety and withdrawal, and in some cases descriptions of differences in defensive functioning (Bion, 1957; Searles, 1962, 1979). But they did not delineate how the mental organizations of these patients differ from those of neurotic or borderline patients. As a result, it is difficult at times to tell whether the patients they talk about should be categorized as hysterical, borderline, schizotypal, schizophreniform, schizophrenic or bipolar.

The differences between disorders labelled schizophrenic and disorders labelled neurotic seem for some writers to be quantitative: individuals diagnosed with schizophrenia have more intense symptoms that arise from more intense conflict, and are generated at earlier stages of development. These writers believe that while dynamic conflict in schizophrenia is more intense, it occurs on a continuum with the "normal". For some clinicians (e.g. Arlow and Brenner, 1964), the dynamic conflicts themselves are believed to be simply more intense versions of those we recognize in neurotic patients, albeit elaborated in a "psychotic" way.

Nevertheless, some clinicians have made intriguing points concerning diagnosis. Bion (1957), for example, emphasized that those diagnosed with schizophrenia, despite their psychosis, maintain areas of their personality that are nonpsychotic and that can be worked with.

Searles (1979) believed that certain countertransference reactions were a reliable guide in telling him if he was dealing with a patient who suffered from schizophrenia. He wrote:

> One of the surest criteria I have discovered, by which to know that a patient is schizophrenic, is my finding that I tend to experience myself as being nonhuman in relation to him—to feel, for example, that I emerge, in relation to him, as being so inhumanly callous or sadistic, or so filled with weird fantasies within myself, as to place me well outside the realms of human beings. . . . The one main point which I wish to make here is to caution against our taking refuge, collectively, in an orientation toward our patients . . . an orientation in which we tend to think of psychotic patients primarily in terms of objectifying them for diagnostic purposes—trying to discern wherein they differ from their fellow men, including, of course, ourselves—and in which we attempt to select this or that drug with the hoped-for magical power to reach the patient and affect his thinking and his feeling, without our own selves, our own feelings and private thinking, becoming much involved
>
> (1979: 285)

From a more theoretical point of view, some psychoanalytic writers have tried to describe how the mind is organized differently in "schizophrenia". Freud (1924a, b) understood the heart of psychosis[2] to be the rupture in the relation of the ego to the external world. By means of disavowal, the ego denies intolerable external frustrations, and if need be, tolerates a disruption in its own unity (i.e. splitting). Disavowal leads psychotic patients to experience a "loss of reality". The "loss of reality" for many writers is a crucial factor in the development of psychosis (and in the definition of it) (Federn, 1934, 1943a, b, c; Weissman, 1958; Frosch, 1964; Kernberg, 1975).

Often, psychoanalytic writers defined psychosis as the inability of the ego to discriminate between self and object (Freud, 1930: 57–146; Winnicott, 1953; Jacobson, 1954, 1964, 1967; Little, 1958; Mahler, 1968; Stoller, 1974; Loewald, 1980). Freud wrote: "An infant at the breast does not as yet distinguish his ego from the external world" (1930: 66–67). He goes on to say, "Originally the ego includes everything, later it separates off an external world from itself" (ibid: 68). For Freud, in early development and in psychopathology the "boundaries of the ego" differ from those of the normal adult. Fenichel referred to the "indistinct ego boundaries" (1945: 423) in schizophrenia.

Jacobson (1954, 1957, 1964, 1967) focused on the development of self and object images. For her, patients diagnosed with schizophrenia suffer from a breakdown in the boundaries between self and object representations. For Jacobson, not only is there a refusion of self and object images in psychosis, but also an unleashing of primitive aggression and a dissolution of the ego and superego as distinct structures.

Mahler (1968) also maintained that fusion of self and object images and dedifferentiation are implicated in psychosis. Many other psychoanalytic writers have echoed these themes.

Kernberg (1975, 1984) combined the emphasis on defects in self-object differentiation and defects in reality testing in his "structural" diagnosis of psychosis. He defined reality testing as the capacity to differentiate intrapsychic from external origins of perception, self from non-self and the capacity to realistically evaluate one's own behaviour, affect and thought in terms of ordinary social norms (1984: 18). The capacity to empathize with the social criteria of reality is often the most sensitive indicator of psychotic structure. In Kernberg's structural interview (1984: 27–51), confrontation of inappropriate behaviour, thought or affect and confrontation or interpretation of primitive defences help differentiate psychotic from borderline patients. According to Kernberg, psychotic patients may regress and show deterioration of functioning following such interventions. (In paranoid patients, this method may run into difficulty. Paranoid patients are often guarded and maintain islands of intact ego function, and so may successfully evade disclosure of psychotic thought processes. It may take several interviews to distinguish between paranoid psychosis and paranoid character (Kernberg, 1984: 46).) I will discuss the treatment implications of Kernberg's structural diagnosis below.

From the standpoint of contemporary ego psychology, Eric Marcus (1992) described the difficulty that the psychotic person has in discriminating between objects in the external world and affective experience in the internal world. He believes that what he terms "reality experience" (the perception of the external world and associated mental concepts) is infiltrated by subjective emotional experience. Percepts associated with external reality become coloured by personal emotions and the boundary between inside and outside breaks down.

Jacques Lacan developed a different point of view about the structure of the mind in psychosis (1955–56, 1959), believing that the laws of the common culture (represented by the Name of the Father) were not adequately installed in the mind of the psychotic patient. Without this process, the mind functions in a radically different way. I will discuss these ideas further in Chapter 10.

Psychodynamic structural diagnosis and treatment implications

The relationship between the diagnostic assessments of psychosis and the approach to psychological treatment has been unclear in psychoanalytic thought. Until relatively recently, diagnosis had little to do with psychotherapy and how it is conducted. The psychodynamic therapist simply focused on dynamic themes and used clarification, confrontation and interpretation as his tools. Whether a patient was hysterical, obsessive, psychopathic, inhibited, impulsive or psychotic made relatively little difference. In general, diagnosis, as it related to psychotherapy practice, played a very minor role. (When a clinician thought a patient was not amenable to insight work, the patient was treated with supportive techniques.)

Eissler (1953a) was one of the first to provide a conceptual framework for modifying psychoanalytic technique according to the patient's particular psychology. He emphasized that one might have to modify traditional technique based on the presence of certain pathological modifications of the patient's ego. If the psychological disorder had impaired the patient's ego functioning, the patient would not be able to participate in a "basic model" of psychoanalysis. Eissler suggested, in fact, that one might make a diagnosis of the patient's ego functioning based on the extent to which he could participate in a "basic model" psychoanalysis.

Kernberg (1975, 1984; Kernberg et al., 1989) followed in Eissler's path, and developed a diagnostic system that was not only descriptive, but also structural. Whereas descriptive diagnosis had only guided clinicians in selecting organic forms of treatment, it was hoped that the structural diagnosis might guide clinicians in the application of psychological methods of treatment. For Kernberg, the use of traditional psychoanalytic therapy was not appropriate for certain patients with severe character disorders. Such patients were impulsive, expressed excessive amounts of unmodified aggression and devalued their therapists. Moreover, they acted self-destructively in ways that overwhelmed traditional verbal therapies. Also, their use of primitive defences made it impossible for more traditional forms of transference neurosis to develop, and produced instead grossly distorted transferences that often had little to do with actual early experience. These patients' behaviour frequently made it impossible for the therapist to remain neutral, and able to think calmly about the clinical material.

Based on his view of the specific causes of ego weakness in these patients, Kernberg proposed modifications of traditional technique. These modifications included the use of limit setting; structuring the treatment in the initial phase to reduce acting out and self-destructiveness; a focus on the interpretation of the transference in the here and now; a focus on the confrontation and interpretation of such primitive defences as splitting and projective identification; and a focus on the confrontation and interpretation of negative transference. These techniques were intended to address the specific psychotherapeutic problems of a specific patient group—borderline patients. These changes in technique were intended to deal with symptoms that sprang from a particular psychological structure that differed from that of the neurotic patient. The goal of these modifications was to increase the power and specificity of psychotherapy with this particular patient group.

Clearly, patients diagnosed with schizophrenia are very different from the kinds of neurotic patients for whom psychoanalytic therapy was first invented. Nevertheless, there has been little written about how traditional technique should be specifically modified to treat these patients. Most of what has been written from a psychoanalytic viewpoint has focused on questions of etiology. Accounts that have examined technical issues have often been nonspecific and vague. Some authors have provided extremely provocative and stimulating reports of their work and clinical theory (Bion, 1957; Searles, 1962, 1979) but have not tried to systematize their recommendations about therapy. Several authors (Semrad et al.,

1952; Will, 1975) have given some very useful general guidelines (e.g. "stop, look and listen"), but omit details on how to address specific clinical problems in working with psychotic patients. They do not tell us how, for example, to approach thought disorder, looseness of association, provocative behaviour, delusions or countertransference disgust and rage. Moreover, these writers do not link their recommendations with a specific formulation about how patients diagnosed as schizophrenic differ structurally from neurotic or borderline patients.

Federn (1934, 1943a, b, c) is a notable exception. He presented a set of recommendations for psychotherapy with people diagnosed with schizophrenia based upon his views of the specific defects in their ego functioning. He developed his technical prescriptions deliberately out of his clinical theory. While I do not agree with many of his conclusions about the psychology of psychosis or its treatment, he deserves credit for attempting to link a structural diagnosis with psychotherapy technique.

My aim in this book is to identify and describe psychological mechanisms that may be at work in schizophrenia. I will describe a treatment approach that tries to take into account the fact that the psychology of psychosis is different from the psychology of neurosis or borderline conditions. If we understand the psychological organization of the mind in psychosis, we may be able to develop a more specific and focused treatment for it. In Chapter 6, I will present my own view of psychic structure in schizophrenia, and its implications for psychotherapy.

The approach to psychodynamic diagnosis used in this book

I would like to add a few words about diagnosis from my own perspective. In some ways, the more I have learned about psychosis, the less clear I am about the usefulness of various diagnostic categories and in particular their helpfulness in determining which patients might benefit from psychotherapy and which patients might not. There are patients who are floridly psychotic who benefit, and some who are much less symptomatic who do not. There are patients who have been psychotic for many years who benefit, and those who have only recently developed psychotic symptoms who do not.

A pragmatic approach to the question of diagnosis

Clearly, the diagnosis of "schizophrenia" is fraught with controversy. Nevertheless, therapists can use a guideline to help them decide which psychotherapy techniques to use, and under what circumstances. I try to make the case in Chapter 6 that the minds of individuals with psychosis function differently from those of individuals diagnosed as neurotic. I will outline these differences and their treatment implications. But because there is so much that is as yet unknown about the psychology of psychosis and its treatment, we may approach the question of evaluation and treatment technique pragmatically:

There are some who have psychotic symptoms, who, more or less, can make use of a traditional verbal psychotherapy. Despite their psychotic symptoms, they are able to use language conventionally, they are able to report their inner states, they can listen to the therapist's observations and they can learn to observe themselves differently as a result of the ideas generated by therapeutic process.

By contrast, some patients with psychosis cannot function in this way. Their ability to form an alliance with the therapist is impaired. They can have difficulty forming enduring attachments. They cannot identify their inner states, and can have particular difficulty tolerating their emotions. Their sense of the boundary between themselves and the external world including the therapist has broken down. They may act as if they have authority over the possessions or actions of others. The behaviour and emotions of others can, with little barrier, affect their inner states. They have difficulty using words to communicate their inner experience, especially emotions. They may react to the world very concretely and have little capacity to think with abstract concepts or use them to organize their inner experience. Thoughts and feelings may occur to them in a jumble. This group of patients have trouble making use of traditional psychotherapy which so profoundly depends on intact language use.

I make an effort in Chapter 6 to describe the psychological functioning of this second group and to describe the way in which the mind is organized (structured) in them. From a practical standpoint, these two groups may require different therapeutic approaches. The first group may benefit from traditional verbal psychotherapy. The second group may require modifications of psychotherapy technique designed to address the particular psychological structure of their minds; that is, the particular impairments in interpersonal, verbal and conceptual functioning. These modifications are the subject of the rest of this book.

For now, I will give examples of the treatments of two patients with psychosis, one of whom could make use of traditional psychodynamic psychotherapy, and one of whom required a modified approach.

A successful use of conventional verbal psychotherapy

Example: William Ishida

William Ishida was a man of Japanese ancestry. He grew up in a suburban town in Arizona. His mother worked outside the home and often left her children to the care of baby-sitters. He recalled feeling that he was not picked up or cuddled enough. His father was a quiet and withdrawn man who did not play an active role in his care or the care of his three younger sisters.

In his early thirties, Mr. Ishida was treated for a number of depressive symptoms: sadness, anorexia, early morning awakening, diurnal mood variation and suicidal thoughts. He was prescribed antidepressants and his symptoms gradually improved. During this time, he had episodes of trancelike states in which he seemed inaccessible, and other episodes in which he seemed overcome with emotion.

In his late thirties, Mr. Ishida married a somewhat older woman. Shortly after, she developed a chronic illness. Mr. Ishida became her almost constant caretaker and sexual relations between the two were forsaken. Finally, his wife required hospitalization for an extended period of time. Within a few weeks, Mr. Ishida became psychotic. He adopted rigid postures for long periods of time, became unresponsive and heard voices telling him to harm himself in a variety of violent ways. He had experiences of derealization and depersonalization, and had visual hallucinations in which he saw worms crawling on his feet. During this time, Mr. Ishida had some depressive symptoms as well which included sadness, hopelessness, feeling slowed up and loss of emotion. He did not experience anorexia or diurnal mood variation. These symptoms continued on and off for several months. He was treated with nortriptyline 200 mg per day for six months, trifluoperazine 10 mg per day for six months, and lithium citrate 900 mg (with a blood level of 0.8 meq/L) for four months without much benefit. He was treated with these medications before second-generation antipsychotics were developed. Finally, he was admitted to an acute care unit and diagnosed as having a major depressive episode.

It was impossible to obtain a detailed family history of psychiatric illness. Mr. Ishida's family had returned to live in Japan many years before and were unavailable for interview. He maintained minimal contact with them and did not know the details of their medical histories. He denied alcohol or drug abuse. A neurological exam and an electroencephalogram several years before had both been normal.

After admission to the inpatient service, Mr. Ishida was given trifluoperazine 30 mg per day for over one month, followed by fluphenazine 20 mg per day for an additional six weeks. He also received desipramine 200 mg per day for a total of two months. None of these medications had an impact on his symptoms. He was frequently placed in seclusion and had episodes of violent rage. He was preoccupied with aggressive and sexual images and fantasies and was terrified if anyone on the unit came too close. After two months' poor response to medication, the diagnosis was changed to schizophrenia. Mr. Ishida was transferred to a facility that emphasized psychotherapy as part of the treatment approach.

Mr. Ishida's new psychiatrist, Dr. Keenan, began a twice-weekly psychotherapy which focused on his affect. During the first few weeks, Mr. Ishida expressed enormous rage toward the staff, the therapist, his wife and his parents. Some of this was expressed rather incoherently, but some was comprehensible. The therapist interpreted that Mr. Ishida's fear of closeness reflected a conflict: he had an intense longing for contact (i.e. to be held and caressed), but because of his fear of abandonment and his anger, he was afraid that contact would also lead to aggression and danger. Dr. Keenan interpreted that Mr. Ishida was not sure whether he wanted to hug people or attack them.

Mr. Ishida began to relax his tense wariness within the first week of psychotherapy. Shortly, he was able to sit in a chair for a full session, and to express himself coherently. In addition to the themes of wished-for contact and fear of violence, the next several weeks were spent exploring his sexual concerns and frustrations.

Within several weeks of admission to the new facility, Mr. Ishida was no longer psychotic. On a few occasions, for only minutes at a time, he experienced some hallucinations, but these quickly faded and he never again had psychotic symptoms. He continued his treatment in the hospital for several more weeks, and was then discharged. He was able to remain nonpsychotic for at least a year and a half on follow-up.

A successful use of specific modified techniques

Example: Mary Williams

Mary Williams (see Appendix) was a twenty-year-old woman from an impoverished city neighbourhood. She was born to teenage parents who were poor and had little education. Her physical development was normal. Her psychiatric symptoms as a child included social isolation, self-injury and aggressiveness. She was often afraid to be with other children, and often did not go to school, spending hours alone at neighbourhood video arcades. As she got older, she became more verbally and physically aggressive and bizarre. Finally, in her mid-teens, she ran away from home, crossing the country from Illinois to Texas, where she lived in a shelter for runaways. At the time of her hospitalization, she was noted to have symptoms of depersonalization, derealization, looseness of association, tangentiality, circumstantiality, paranoid delusions (she thought her grandmother was a member of the Ku Klux Klan and intended to harm her) and auditory hallucinations (she heard the President talking to her). She had abused alcohol, marijuana and phencyclidine in the past. Her symptoms had been present for two years, and had been treated without benefit with chlorpromazine 100 mg per day for several months before her hospitalization. The diagnosis made by several clinicians on admission was chronic undifferentiated schizophrenia according to DSM-III criteria. Psychological testing concluded that she had a "severe" loss of reality testing, a disturbed sense of boundaries and autistic and referential thinking, and that she felt that inanimate objects were alive.

It was not possible for the hospital staff to locate Ms. Williams' family in Illinois and no independent family history was available. A routine neurological exam revealed no abnormal findings. Ms. Williams was treated with fluphenazine 10 mg three times per day for the many months of her hospital stay. This was associated with some reduction of her auditory hallucinations and delusions, but not of her thought disorder and bizarre behaviour.

On the hospital unit, Ms. Williams was loud and provocative, disrupting morning meetings with rambling and largely incoherent speeches. When asked to refrain from being disruptive, she became defiant. When she first met with her psychotherapist, she sat quietly for a few moments, and then lay on the therapist's desk. When the therapist asked her to go back to her seat, she laughed excitedly. On other occasions, she tried to unplug the therapist's telephone and answering machine. When Ms. Williams was feeling especially sad and hopeless, she stopped

coming to psychotherapy sessions altogether. When she was finally encouraged to come to a meeting with her therapist, she denied feeling any painful emotions, instead reporting a "heavy feeling" over her heart. At other times, while appearing emotionally distressed to others, she talked about feeling empty.

Overall it seemed that she found it very difficult to identify her inner states, to bear and contain powerful affects, to be able to be curious and reflect on her experience, to avoid putting emotions into action, and to imagine what her therapist might be feeling. She often seemed to act as if her therapist's belongings were her own, and to be confused about whose inner experience belonged to whom. When the therapist attempted traditional verbal psychotherapy, her impulsivity, provocations and mocking attitude overwhelmed the psychotherapeutic framework. She would not discuss her inner life, and would not sit still long enough to listen to what the therapist had to say. Even when she wasn't frankly disruptive, her speech was so disorganized that it was impossible to understand what her emotional experience was.

Despite the problems described above, using many of the techniques described in Chapters 6 and 7, including the structuring of boundaries, monitoring the interpersonal relationship, awareness of emotional induction, naming and enlargement and a specific approach to pressured speech and looseness of associations, Ms. Williams and her doctor were able to establish a working therapeutic relationship. Ms. Williams was able to control her disruptive behaviour and eventually to bear painful and warded-off emotions. She began to link her symptomatic behaviour to comprehensible psychological conflicts and to make emotional connections to her peers. Initially isolated and defiant, Ms. Williams was eventually able to express poignant feelings of sadness and loss and to feel less alien and more human. Her symptoms were substantially reduced and she became a participant in the social life of the unit.

Notes

1 Much of this section on descriptive diagnosis draws upon *The Treatment of Acute Psychotic Episodes* (Levy and Ninan, 1990).
2 The terms "psychosis" and "schizophrenia" will be used interchangeably here. The psychology of affective disorders is not a focus of this bookwork.

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3

STRUCTURING THE TREATMENT

The rationale for structuring the treatment

While the ultimate goal of psychotherapy with patients with a diagnosis of schizophrenia is to reduce symptoms and their devastating effects, clearly this cannot be achieved quickly. Medication and organic forms of treatment usually take time to produce results, and this is all the more true for psychotherapy. Also, a deep psychotherapy process is not something that occurs immediately, even if the treatment is begun soon after the psychosis starts. It is a collaboration that both parties must learn to take part in together. As I discussed in Chapter 1, psychosis may come about for many different reasons. One important psychological factor is that psychotic experience may be a way of warding off emotions that, if directly faced, feel too difficult for the patient to bear. It is crucial to find a way to make contact with the non-psychotic part of the psychotic person's personality, and to limit the extent to which the person can distort the psychotherapy relationship, thus avoiding the emotions that feel so frightening. This chapter is an effort to describe the ways in which patients may be motivated to disrupt the psychotherapy process and steps that can be taken to limit such disruptions.

Work with patients who have severe character disorders has shown that some may not be able at the outset to participate in verbal psychotherapy. In fact, they may not know what psychotherapy really consists of. Borderline patients often translate feeling into action rather than words. Self-destructive impulses may find their way into self-cutting, neglect of essential medical treatments, inattention to work or school deadlines and so on. Moreover, even verbalizations in psychotherapy can constitute "acting out". Kernberg (1975) cites the example of a patient who yelled at her therapist session after session. He concluded that this was not "working through", but rather a repetitive gratification of aggressive wishes. When the therapist told the patient to stop, for the first time anxiety and concern appeared.

Borderline patients require modified psychoanalytic technique, in part because, unlike neurotics, they cannot follow the "fundamental rule" of psychoanalysis. Because they rely so much on splitting as a defence, it is especially important to point out their contradictory feeling states. Because of the patient's use of splitting, the therapist must help him make connections between ideas and feelings

that have been kept apart. And because these patients express so much in action, setting up parameters (Eissler, 1953; Kernberg, 1975) and establishing limits are also more central to the treatment. These steps are taken to preserve the *verbal* nature of the treatment. A treatment that does not call upon the patient to verbalize rather than to act is not psychotherapy. If impulses are gratified rather than spoken, understanding cannot occur. Setting limits on the patient's behaviour has the following goals: (1) to preserve his safety (a severely injured patient cannot participate in psychotherapy); (2) to preserve a minimum level of calm and equanimity so that the therapist can think and feel freely; and (3) to channel powerful affect and hard-to-tolerate thoughts into comprehensible words, rather than incomprehensible action.

These challenges to establishing a verbal psychotherapy in borderline patients are even greater in work with severely psychotic patients, whose speech is often incomprehensible, and who may use words to obscure meaning instead of communicating. Not only is the verbal apparatus dismantled in some of these patients, but so also is their capacity to think in concepts. The mechanism for translating emotions into words is impaired. In other words, the capacity of these patients to symbolize is lost. These patients do not have a language for their inner states. They may transform ideas and emotions into sensations, and thus remove themselves from the conceptual or verbal realm.

As if this were not enough, many of these patients have a devastating breakdown in their capacity to maintain a relationship. Deeply vulnerable to the loss of self-esteem, and longing profoundly for closeness to the point of fantasied merger and fusion, and deathly afraid of their own rage and the retaliation of others, they can break off treatment for good with little notice. The fear of their own aggression may be compounded by their inability to distinguish between themselves and others. Thus, aggressive fantasies of attack and counterattack spill over into their view of the therapist, making it impossible for him to be a helpful ally. The clinician then is perceived to be dangerous, and the patient contemplates fight or flight. Such fantasies may poison the therapeutic relationship. Accepting an "interpretation" from a therapist perceived to be dangerous requires a faith and freedom from suspiciousness that do not exist.

Sometimes such patients may try to control the therapist's behaviour and speech to protect themselves from frightening amounts of their own envy, rage and anxiety. This may leave the therapist with the unfortunate options of remaining silent, leaving essential material undiscussed, or speaking up, and appearing to the patient to be attacking.

Psychotic patients will often deny the realistic consequences of their actions in the outside world, and disrupt treatment by getting themselves hospitalized, arrested or cut off financially from family support. They may spend such vast amounts of time in unrealistic activities or isolated fantasy states that no psychotherapy relationship can compete for access to their inner worlds. Such "autistic" states may be deeply gratifying. They permit the fantasy that the patient has escaped ordinary human limitations, and that he is not subject to the same confines

of time, space, death and loss as his fellows. From such a perch, what would induce a patient to reenter the mundane world and discover the true outlines of his social, cognitive and emotional impairment? To say that such a patient "lacks motivation" for psychotherapy is often a profound understatement.

Psychotic patients can disrupt their psychotherapies by making themselves so offensive and obnoxious to the therapist that he can only think of ridding himself of his burden. The patient can make the therapist feel impotent, empty, dead, fraudulent, immoral, self-centred, frightened, crazy, enraged or revolted. In the best of circumstances, such countertransference affects are conscious and the therapist has a fighting chance to deal with them. Often, however, many operate unconsciously, and may lead the therapist to find a rationale to have the patient treated elsewhere.

For any psychotherapy to work, several essential things must be in place: (1) The patient must be able to come; (2) he must have a wish to tell his story to someone who will listen; (3) he must have the conceptual wherewithal to do this; that is, he must be able to put his ideas and feelings into words; (4) he must have financial resources, or the support of those who do; (5) he must find someone willing to try to make sense of what he says; and (6) he must refrain from attacking the physical setting or the composure of the therapist so that he can pay attention to what the patient has to say.

One of the basic tasks of the psychotherapist is to create conditions necessary for a verbal psychotherapy. He accomplishes this by identifying the factors that prevent this from happening. Some of these, such as the patient's disturbances in symbolization and in the self-object boundary, can be ameliorated only slowly. Some, such as the patient's yelling, refusing to take medication or sleeping twenty hours a day, can and should be addressed at the outset. The purpose of this chapter is to outline some principles that can be used to structure verbal psychotherapy with patients diagnosed with schizophrenia.

There are generally three ways in which the patient can disrupt the basic conditions for psychotherapy:

1. The patient's behaviour so gratifies (usually split-off) impulses, or is such an important defence, that he is unwilling to examine it psychologically (Kernberg, 1975). This may occur if the patient verbally abuses the therapist, threatens harm, damages physical property, uses drugs and so on.
2. The patient's behaviour so alienates, disturbs, frightens, stimulates or disrupts the therapist that he or she is either unable or unwilling to maintain technical neutrality, or even to listen to the patient at all.
3. The patient's behaviour destroys his ability to attend sessions. This may be accomplished by alienating supporting family members, destroying sources of income or insurance coverage or spending long stretches of time in the hospital.

What follows will focus mainly on outpatient treatment. Some of what I will say follows Kernberg's (1975, 1984) suggestions concerning the psychotherapy of people with borderline personality.

An approach to structuring therapy

Example: Ms. Jackson

I would like to begin with a case example that illustrates many of the problems of outpatient treatment with patients diagnosed with schizophrenia.

Helen Jackson came for treatment at the request of her grandparents. Ms. Jackson was orphaned when her mother, who had been divorced from her father, died during the patient's infancy. After a brief spell in foster care, she had been sent to live with cousins, the Jordans. She lived with them until Mrs. Jordan had a stroke and was institutionalized when Ms. Jackson was in her mid-twenties. Following this, she lived for a time with her aunt and uncle, the Tafts, in a rural community. She was hospitalized on many occasions for auditory hallucinations, paranoid and grandiose ideas, bizarre behaviour and poor self-care. She graduated from high school, but had trouble keeping simple jobs. Nevertheless, she believed that, one day, she would become a well-known and successful businesswoman. She had a profound thought disorder, with marked loosening of associations, and marked tangentiality. Her affect was very often inappropriate and restricted. She was not easy to live with. Her behaviour was frequently very primitive. While living with the Tafts, she would throw garbage out of the window onto the lawn and her dirty laundry out on the street.

The Tafts anticipated problems with the arrival of Ms. Jackson. On the advice of their pastor, they arranged for her to see a therapist soon after she settled in. Although it was unstated, part of their motive was to prevent their niece from being a "behaviour problem". Because of powerful feelings of family obligation, they felt unable to refuse her request to live with them, but clearly feared that her presence would upset their way of life. In the beginning, Ms. Jackson's uncle was willing to provide transportation for her to attend twice-weekly psychotherapy. This represented a considerable commitment since it took about twenty minutes each way by car, and public bus or train services did not exist between their home and the therapist's office.

For her part, Ms. Jackson was undecided about whether she wanted to live with the Tafts whom she thought had little time for her, or whether to live with vaguely identified friends. She got the message that her aunt and uncle wanted her to be in better control. She attended her psychotherapy sessions, but soon expressed a wish that she and the therapist make her quickly "recovered" so that she could leave town and return to live with her friends. She wanted to get on with her plans to get a job and succeed in the business world.

Ms. Jackson began her tenth session by walking into a group run by a colleague of the therapist's in another office in the suite. She grudgingly left after the group leader asked her to do so. Her therapist, Dr. S, later explained that the work with the group was private, and that she could not enter offices other than her therapist's. The therapists in the suite needed to safeguard the privacy of all the patients as well as that of Ms. Jackson, she explained.

Several times during this period, Ms. Jackson removed journals and books stored in a closet next to the waiting room. Dr. S advised her to return the material

and asked why she had taken it. Ms. Jackson answered that she was curious, and laughed. The therapist then told her that this made her angry, and that Ms. Jackson was treating her things as if they were her own. If they were going to meet, Dr. S said, then the patient would have to stop this. The therapist also wanted to discuss why Ms. Jackson had acted as she had. They discussed Ms. Jackson's feeling that she was a burden to her relatives, and her envy of the therapist.

As time went on, Ms. Jackson and her therapist were able to do much productive work. Progressively, she was able to put her feelings of failure, isolation, loneliness, emptiness, rage and envy into words. Despite various disappointments and outbursts of rage at Dr. S, she persevered.

The therapist had explained to Ms. Jackson and her family that it was essential that she have some structured therapeutic activity during the day, such as a training programme or day hospital, so that the psychotherapy did not bear the entire brunt of her treatment needs. She also explained that psychotherapy was not the answer to all of Ms. Jackson's problems. Ms. Jackson and her family agreed. For weeks afterwards, Ms. Jackson told her therapist that she was attending an agricultural work programme which was training her for a farm job, and which in fact she had applied for.

Within a short time, the structure of the psychotherapy began to crumble. The Tafts reported that after several weeks of good participation in the farm training programme, Ms. Jackson had stopped attending. When confronted with this, she dismissed the significance of both her failure to attend and her lying about it. Also, Mr. Taft, who was responsible for driving her to the sessions, began to complain of the inconvenience. This seemed to represent some unspoken criticism of the psychotherapy. Ms. Jackson began to talk increasingly about the need for speedy treatment, and her wish to return to live in the South. When she was asked, she acknowledged that her uncle said it was hard for him to do so much driving. Suddenly, Mr. Taft told Ms. Jackson to stop her sessions, and she called Dr. S to end the treatment.

The above account is a very incomplete summary of Ms. Jackson's history, and leaves out many of the details of the psychotherapeutic work. More of this work will be presented in later chapters. Nevertheless, this vignette illustrates a number of problems one encounters in setting up psychotherapy with a psychotic patient and the patient's family.

An approach to structuring Ms. Jackson's psychotherapy

For this treatment to have had a better chance of success, I think the therapist's interventions should have gone beyond limit-setting within the sessions. The following steps might have been helpful.

1. Ms. Jackson could have been referred to a day treatment or vocational setting for her to attend a significant portion of the week. Her participation in this programme should have been monitored more closely, and noncompliance

should have been explored as a challenge to the integrity of the treatment. Too much unstructured time permitted this patient too great an opportunity for unproductive fantasizing and acting out. Such unstructured time can be experienced as an abandonment, and can increase a person's fears of disorganization and subsequent anxiety and rage. It also can contribute to the patient's denial of his needs for others, and his interpersonal problems by means of autistic withdrawal. In this kind of emotional climate, psychotherapy often carries little weight compared with the patient's fantasies. Moreover, if the patient's social, rehabilitation, medication and vocational needs are not addressed elsewhere, the psychotherapy is overwhelmed, and cannot focus on the goal for which it is best suited: to help the patient understand himself psychologically. Two or three sessions per week of psychotherapy cannot replace the whole range of essential treatments needed to help alter a patient's actual life situation. Psychotherapy on its own cannot transform the life circumstances of a patient such as this. At its best, it is part of an overall approach that includes significant social and vocational rehabilitation. Psychotherapy is a commentary on life, which can lead to changes in affect, attitude and motivation. But it cannot substitute for learning actual intellectual, social and vocational skills that the patient needs to master. Such deficiencies, even if they have resulted from psychic conflict, need skilled help from tutors, occupational therapists and vocational counsellors.

2. The patient's uncle and aunt could have been included more in setting up the treatment. While the plan of the treatment, including the treatment method and the farm programme, were explained to the Tafts, they did little to monitor the patient's participation. Both the uncle and aunt were preoccupied with other matters, however, and might not have been able to do this even if it had been stressed.
3. The issue of transportation could have been clarified sooner. Most likely, the uncle's ambivalence about the psychotherapy would have emerged sooner, and the issue could have been discussed more explicitly. The patient might have had more time to integrate the uncle's mixed feelings about the treatment, and discuss this with the therapist.

The outcome of this specific treatment might very well have been the same even if all these issues had been addressed as I have suggested. I use this case to illustrate some of the crucial issues in setting up psychotherapy with psychotic patients, not to claim that Ms. Jackson's therapy would necessarily have had a different course.

Acting rather than thinking or feeling: behaviour within the treatment setting

Disruptions in the treatment setting may take rather bizarre forms, including attacks on the boundary between therapist and patient.

Example: Mary Williams

Mary Williams was a twenty-year-old woman who had lived a very isolated life before admission to a hospital unit. She began psychotherapy with Dr. C, a woman, soon after her hospitalization. During one of the early sessions, Ms. Williams wandered around Dr. C's office, trying to unplug all the electrical devices. She tried to take coins from Dr. C's coat, and asked if she could have various articles of clothing. She lay down on the sofa, putting her feet on a nearby chair. On several occasions, she barged into the offices of colleagues in the therapist's suite and would not leave when asked. She constantly tried to put on Dr. C's overcoat, and all Dr. C's efforts at confrontation and interpretation did not help Ms. Williams understand or stop her behaviour.

After several weeks of this, the therapist finally told the patient that it would be necessary to meet with her in the common room of the unit, where staff members could observe them. Dr. C said that the staff would help her to be in control so as not to destroy the sessions. The staff would also prevent her from invading Dr. C's privacy. Despite bitter complaints, Ms. Williams did attend these sessions, and settled down dramatically. She began to do introspective work for the first time. Dr. C believed that she was reassured that she did not possess the power to blackmail and intimidate the therapist, and thereby destroy the foundations of a serious psychotherapy.

Later on, Ms. Williams took to turning her chair so that her back faced the therapist, while affecting a flippant nonchalance about what the therapist was trying to point out to her. Dr. C finally asked the staff members to turn her around. She was shocked and initially outraged that Dr. C would do such a thing, but returned to later sessions more serious and ready to work.

While it is generally not possible in outpatient settings to compel the patient's attendance, or to have colleagues prevent physical disruption, still this case illustrates the need not to accept an unproductive stalemate in the treatment. The patient may feel nihilistic and hopeless, but the therapist should not be overwhelmed by the same feelings of impotence and despair. It is the therapist's responsibility to find creative ways to arrange the conditions for psychotherapy and so begin a collaboration with the patient, or to tell the patient that psychotherapy is not possible. To avoid doing this is to collude with the part of the patient that wants to destroy meaningful treatment or avoid it altogether. It is to acknowledge tacitly that one is not only impotent but unwilling to face therapeutic reality. This can undermine the patient's residual capacity for reality testing.

Frequently, patients diagnosed with schizophrenia place their therapist in painful dilemmas. On the one hand, one does not want to enter into battles with the patient, intrusively challenging deeply held beliefs or delusions, running headlong into painful emotional wounds or provoking rage that can annihilate the relationship. On the other, it is futile to accept a relationship that gratifies the patient's destructiveness, undermines his capacity to separate fantasy from reality or makes the therapist so uncomfortable that real psychological exploration is impossible.

To some it may appear callous to reject a patient because he or she is unwilling to meet twice a week, or participate in a day hospital programme or take medication if it is indicated. After all, are these problems not part of the patient's illness? But not to stand by these measures, if they are prerequisites for productive psychotherapy, is not to do the patient any favours. Many patients are used to parental figures who choose expedient but ultimately unhelpful solutions to grave problems. Many also understand when their efforts to destroy help have succeeded, and they feel abandoned and frightened when they are able to annihilate their treatment.

Moreover, I am not suggesting that all patients diagnosed with schizophrenia must choose to participate in psychotherapy, or that all therapists should refuse to work with them if they do not abide by the necessary preconditions. For some patients, other forms of treatment such as directive treatments, medication or different forms of psychotherapy may be more tolerable and more useful. But if patient and therapist agree that psychodynamic psychotherapy, with all its potential risks and benefits, should be tried, it does not serve the patient to agree to a treatment structure that cannot succeed.

Sadistic gratification and devaluation within the treatment

In emphasizing the importance of prerequisite conditions for beginning psychotherapy, I am not minimizing the patient's impairments, and how difficult it may be to meet such conditions.

Example: Mr. Wood

Dr. V worked with Mr. Wood for a number of years. It was unclear to Dr. V whether this man's diagnosis was paranoid character (DSM-IV TR) or whether he was structurally psychotic (Kernberg, 1975, 1984) (see Chapter 4). When confronted about his paranoid beliefs, Mr. Wood consistently became evasive and more agitated. Nevertheless, he maintained a senior administrative position in a university, and had some friends and several girlfriends. These relationships were essentially need-satisfying and shallow. His sister, and probably his uncle, had been diagnosed with schizophrenia. It was difficult for the patient to empathize with others, and his social disappointments led not only to his seeing others as all bad, but to severe paranoid anxieties. His predominant defences were splitting, projective identification, omnipotent control and denial.

On one occasion, the patient expressed suicidal ideas and agreed to a contract. He would not harm himself, but would call the therapist every day or two; however, on several occasions, he did not. Moreover, when the therapist called there was no answer. This left Dr. V feeling quite anxious, having little information upon which to make the decision whether to call the patient's relatives to find out if he was safe. The patient later told Dr. V that he had "fallen asleep" and so

could not call. The therapist emphasized that it was essential at times of crisis that he be able to contact the patient reliably, otherwise the therapist would be unable to be calm enough to listen to the patient in sessions, and they would not be able to work together.

Several months later, the patient became more and more paranoid. His suspicions did not diminish with confrontation and interpretation. He went on to develop a transference psychosis. He came to a session with only ten minutes left, and then talked distractedly about seemingly trivial details of the day. During the next session he reported some suicidal thoughts, and agreed to make a brief office visit the next day to see Dr. V for follow-up. Dr. V waited, but the patient never came. Dr. V received no phone call or message. Finally, he called the patient's office. The patient, he learned, had gone to an academic meeting out of town. Upon the patient's return, Dr. V discontinued the psychotherapy, referred the patient elsewhere and explained that he had destroyed the conditions necessary for Dr. V to work with him. Dr. V said that because of the patient's lack of contact, he was constantly worried about the patient's safety, and this made it impossible for him to think calmly and clearly about the patient's psychotherapy.

It was difficult for Dr. V to terminate this treatment. Both the patient and the therapist had put in time and effort. But Dr. V felt that if the treatment had continued, there would be no effective limit on the patient's use of suicidal threats as sadistic gratifications, and as self-destructive attempts to destroy the psychotherapy. In addition, during the periods in which the patient was incommunicado, Dr. V found himself so preoccupied with the concrete details of the patient's whereabouts and safety that he really did not have the psychological freedom to reflect on his dynamics and defences and to formulate a good understanding of what was going on. Dr. V also found himself so preoccupied with countertransference fear, worry, anger and resentment that it was difficult for him to think creatively. Perhaps the patient could use his experience of destroying this treatment to pause, reflect and begin another psychotherapy in a more constructive way.

Example: Mr. Green

Mr. Green had been seeing Dr. H for about one year when he started to work at a paying job. He used much of this money to buy expensive sports and electronic equipment. Up to this time, his family had been paying for his treatment. About six months after he started at his job, Dr. H began to discuss the possibility of his contributing to the payment. Mr. Green became furious, accused Dr. H of being "money hungry", and protested that he could not part with any of his money. He became extremely suspicious and combative, saying that Dr. H did not want him to get better. In fact, he declared, he would not discuss this subject anymore.

Dr. H felt that it was important for this patient to pay something because he had devalued the treatment in many overt and covert ways. He had skipped appointments to go skiing, and rarely paid on time. Now, he seemed to be saying that the therapy might be worth his parents' money, but not his own hard-earned savings.

After some time the patient agreed to pay. His participation in his treatment became noticeably more serious and productive. Not paying had been a way of expressing derogation of Dr. H, of maintaining an image of himself as both infantile and special, and of holding onto a self-destructive attachment to his parents whom he felt were engulfing and undermining.

Induction of disruptive countertransference

Some enactments are subtle and operate via their countertransference impact on the therapist. I will discuss this further in Chapter 4, but will give an example here.

Example: Mr. DeVito

Mr. DeVito had been in treatment for many years. There had been ups and downs, but he had remained out of the hospital for five years and was functioning at work. Nevertheless, the sessions had taken on a repetitive, dull and soporific quality for months. Mr. DeVito had gained weight, he dressed drably and had little to talk about in the meetings. To the therapist he really seemed like a formless lump. In response, the therapist's mind wandered, and at times, during the long silences, he fell into a kind of distracted reverie. He felt comfortable and snug, as if he had just been put into a cozy bed by a parent. At times, he really did not want to be disturbed out of his cozy corner, and have to "wake up" to conduct psychotherapy. After the therapist realized what was going on, he discussed his reactions with Mr. DeVito, and both were able to see that the therapist's feelings mirrored those of the patient.

I will discuss in Chapters 4 and 5 how this countertransference issue can be handled. I offer this example here to illustrate how subtle enactments by the patient can have an important impact on the therapist.

Acting rather than thinking or feeling: behaviour outside the treatment setting

The behaviour of patients outside the consulting room can also have an important effect on their treatments.

Example: Mr. White

Ronald White was a twenty-year-old British man with a borderline personality and psychotic depression.[1] He came for treatment because of a depressive episode, but decided to work in psychotherapy on his social isolation. After a few months, it emerged that he was taking items from the warehouse where he worked and reselling them for cash. When Dr. W asked about this, Mr. White replied that all the guys at work did this, and, moreover, that unless he stole these things, he

could not afford the treatment. Earlier on in treatment, Mr. White had expressed scepticism about the genuineness of the therapist's interest. He was interested, Mr. White contended, because he got paid.

After several weeks' discussion, the stealing had not abated. Finally, Dr. W told the patient that he would not continue to see him if he stole. His stealing represented a deep cynicism about relationships, including the one with Dr. W. It reflected a belief that he could not get something valuable from someone else by their freely giving it—he had to take it against their will, or without their knowledge. And more importantly, in the context of the therapy, it gratified the anger implicit in his hostile image of Dr. W. He essentially saw Dr. W as a hypocrite who professed ethical values, but who did not really care if he was paid with profits from stolen goods, as long as he got paid. Eventually, Mr. White agreed to stop stealing, and was able to explore many of these issues.

Example: Mr. DeVito

Many enactments may not appear to be enactments at all, but just part of the patient's illness.

After five years out of the hospital. Mr. DeVito made tentative efforts to establish a relationship with a woman, and move out from his aunt and uncle's home. Finally, he did move out and talked with his girlfriend about marriage. Within six months he was hospitalized five times. At least two or three of his previous hospitalizations were associated with his moving away from his relatives to live independently. Mr. DeVito's symptoms were florid; he had auditory hallucinations and paranoid delusions. On an impulse, he drove his motorcycle to California where he was picked up by the police for vagrancy. With all this, Dr. B, his therapist, felt that Mr. DeVito made use of his symptoms to avoid the emotional stresses related to intimacy and separation. Moreover, with each hospitalization, Mr. DeVito lost his job and was forced to depend even more heavily on his aunt and uncle. At one point, he spent many months out of work, waking up late and going to the racetrack. He acted, actually, as if he were a man of independent means, living a rather carefree, if limited, existence. There was a bland and thoroughgoing denial of the real-life consequences of the impact of all this on his work and personal life.

While Dr. B understood that the patient had a psychotic disorder, nevertheless he felt that the frequency of the recent hospitalizations and the nature of his post-hospital adjustment were enactments, and that the patient was capable of greater control. Dr. B and the patient discussed these issues in treatment, and developed a plan. They agreed that if the patient were hospitalized again, within four weeks he would be working at a paying job that could support his treatment, or the psychotherapy would be suspended until such time that the patient was earning an income.[2]

The purpose of this plan was to help reduce Mr. DeVito's denial of the destructive impact of his hospitalizations on his capacity to function as an adult. Another

goal was to reduce the patient's effort to turn the psychotherapy into a kind of compensation for past suffering paid for by his uncle which he would then take pleasure in destroying.

Example: Ms. Chen

Ms. Chen had been in treatment for four years. She had a long history of psychotic symptoms including severe paranoid ideas, ideas of reference, delusions that her mind was being read by others and somatic delusions. Nevertheless, she was able to tolerate some social relationships and to maintain a job. She had, for the first time, established a relationship with a man over an extended period of time. They spent long weekends together. This was quite a strain for the patient, who at times was delusional about other people's ability to read her mind, and to influence her. She was extremely sensitive about her "personal space" being intruded upon. She reacted to perceived slights with explosive anger. When her boyfriend criticized her for forgetting to buy concert tickets, she exploded in fury, and precipitously terminated the relationship, her job and her psychotherapy. She maintained sporadic contact with her therapist after that, but remained out of work for many months. Even if she had wanted to return to psychotherapy, she could not have done so because she no longer had medical insurance. In her paranoid fury, she had not only burned interpersonal bridges, but financial ones as well.

Summary

Of course, there is no limit to the variety of enactments that can jeopardize psychotherapy. One cannot coercively suppress all unusual, idiosyncratic, imprudent or pathologically gratifying impulses. The goal of psychotherapy is change via self-understanding and integration, not compliance or submission to the psychotherapist's image of normality or ideal health. At the same time, while recognizing the danger of excessive control, patients can act in ways that severely compromise the possibility of verbal psychotherapy. It is the therapist's job to evaluate how much the treatment may be compromised and to weigh the comparative value of setting a limit. At times, some of the limits one sets may appear controlling or callous to an outside observer, including members of the patient's family. As much as possible, these limits should be explained to both the patient and family.

There are no simple rules of thumb in deciding when and how to set a limit, and these strategic clinical judgments may be quite subtle and complicated. It should be stressed that in making such difficult decisions about limits, the therapist will inevitably make mistakes, not going far enough in some instances, and going too far in others. Nevertheless, it is no favour to the patient to avoid thinking them through, and, if necessary, introducing them. In the end, one may be able to discuss the need for having set limits with the patient, and eventually eliminate them. This is not possible if the patient has already dropped out, or if the patient and therapist have entered a chronic and unproductive stalemate.

I will end this chapter by listing below a set of conditions for effective psychotherapy with a patient who is psychotic. The list is obviously incomplete. It is intended to be illustrative and not a prescription for any individual case.

1. Willingness to report feelings or actions that may lead to danger to the patient or others.
2. Willingness to refrain from attacks or intrusions on the physical setting of the treatment or the personal life of the therapist.
3. Willingness to participate in a full-time, five-day-per-week (or as close as possible to it) constructive activity such as work, a day hospital programme or rehabilitation. Sometimes professional activities or work programmes are not available. In these instances a local community organization (a religious or volunteer programme) may help fill the gap.
4. Willingness to pay (even if partially), or to find and preserve financial support.
5. Willingness to take medication, if and when necessary.

Notes

1 Despite Mr. White's diagnosis of affective disorder, this is a good example of aspects of work with patients diagnosed with schizophrenia as well as psychotic patients more generally.

2 Under these circumstances, Dr. B would continue to prescribe medication and would be available in emergencies. The patient would follow up with any aftercare rehabilitation programme that had been set up in the hospital.

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4

THE PSYCHOLOGICAL THERAPY OF PATIENTS DIAGNOSED WITH SCHIZOPHRENIA

In this chapter, I will describe the organization of the mind in some people diagnosed with schizophrenia and the modifications of psychotherapy technique that may then be needed. I will continue the discussion of technique in Chapter 5, and the discussion of the organization of the mind in Chapter 6.

Psychic structure and disturbances in ego function

Before discussing psychotherapy techniques that are useful in working with patients diagnosed with schizophrenia, it is important to identify the ways in which the organization (structure) of the mind characteristic of psychosis can differ from those characteristic of neurosis. These structural disturbances proceed from modifications or impairments in the patient's ego functioning, and require modifications of standard psychotherapy technique. If, for example, a person diagnosed with schizophrenia has difficulty using words and symbols (Goldstein, 1944), then a standard, strictly verbal form of treatment, based exclusively on interpretation, will be compromised. There are five broad areas of ego pathology that stand out, each of which has been described by a number of psychoanalytic writers. These enduring "modifications" (Eissler, 1953a) in the way the ego functions constitute a characteristic psychic structure that differs both from that found in neurosis and borderline conditions.

1. Disturbance in the capacity for emotional attachment

Many analytic authors have written about the brittleness and vulnerability of object attachments in psychotic individuals (Freud, 1911, 1914, 1924a, b; Fenichel, 1945; Hartmann, 1953). People diagnosed with schizophrenia make human connections with great caution. It is as if a great barrier must be overcome. Despite intense affect, these connections are vulnerable to being broken off abruptly with little provocation, and little warning. These attachments do not have the "staying power" to withstand disappointment, loss or rage. They can quickly change from having a positive emotional tone to having a paranoid one (see Sullivan's concept of "malignant transformation" [Sullivan, 1962]).

Early on, it had been thought (Freud, 1916–17; Fenichel, 1945) that psychotic patients were unable to develop a transference neurosis. Later, clinicians came to believe (Fromm-Reichmann, 1959; Searles, 1963; Sullivan, 1962) that it was not the *absence* of attachment or transference that characterized schizophrenia, but its *quality.* Of the patients described in this book, Ms. Chen stands out as a fitting example.

Ms. Chen established a suspicious but very intense attachment both to her therapist and to her boyfriend. This connection could withstand only modest disappointments and disruptions, but not more. When her boyfriend made a comment she perceived as too critical, she reacted with violent rage, ending the relationship with boyfriend, employer and therapist in a paranoid fury.

2. Disturbance in affect awareness and regulation

Many writers have observed that psychotic patients have difficulty containing, toning down and integrating their impulses, especially aggressive ones (Hartmann, 1953; Bak, 1954); these may break through unmodified. The patient may become verbally abusive, physically threatening or provocative. Recall Ms. Chen's explosions of anger, Ms. Williams' intrusive antics in the office and Mr. DeVito's distracting hallucinations and delusions (Chapter 3). Patients may try to escape from the danger of their impulses by becoming excessively passive, even stuporous or emotionally withdrawn. Or, they may project their hostile impulses onto others.

Ms. Williams reported late in her inpatient treatment that in the early sessions, she had felt like jumping up and punching Dr. C. At the same time, she was afraid that Dr. C. would kill her.

Many people with a diagnosis of schizophrenia have difficulty in tolerating powerful emotions. Enduring the intensity or pain of such affects requires a variety of ego and self strengths that may not be present. One must be able to anticipate that pain will pass at some point. One must have faith that one's sense of self and one's functioning can endure the impingements caused by powerful emotions. One must have relationships with others that are strong enough to survive rage, suspiciousness and precipitous changes in self-esteem so that one can seek help and comfort from others. And one must have methods of toning down and modifying the disruptive intensity of affects that can infiltrate the entire personality.

3. Disturbance in the development and preservation of psychological boundaries

Psychological boundaries are, so to speak, division lines that separate experiences and help them to be distinct in the mind. For example, most people experience a distinct boundary between dreams and waking reality, and between mental images and actual perceptions. Psychological boundaries are essential for the

mind to keep its experiences separate and well defined. Without them, impressions become indistinct and confusing. It becomes impossible to tell what is real and what is not, which is the hallmark of psychosis.

The concept of a "psychological boundary" is complex, and used in the psychoanalytic literature in different ways. For our purposes here, it refers to any one of the following: a confusion about the boundary between perceptions that arise in the self and those that arise in the outside world (e.g. hallucinations); a confusion about whether an experience is part of the self or part of another human being (e.g. an effect of primitive defences such as projection and fusion); a blurring of the separation of the impulsive part of the mind (the id) and the organizing part of the mind (the ego); and a confusion between different kinds of mental contents (e.g. real perceptions vs. memories vs. fantasies vs. wishes). All these processes can lead to a profound disturbance in self-experience and identity.

The patient diagnosed with schizophrenia not only shows a disturbance in the boundary between the ego and the id (Federn, 1943a, b, c; Hartmann, 1953), but also between the ego and the outside world. One of the cardinal and most consequential disturbances in schizophrenia is the patient's difficulty in discriminating what is inside and what is outside, and what is self and what is other. The capacity to distinguish inner from outer experience, what I will call the "sense of boundary", is central to differentiating between perceptions, feelings, memories, fantasies and thoughts, and thus is central to the capacity to test inner (Hartmann, 1953) as well as external reality (Kernberg, 1975). A disturbance of the sense of boundary is intimately linked to such defences as primitive projection, psychotic identification, fusion of self and object images and, consequently, such psychotic symptoms as paranoid ideas, ideas of reference and gross disturbances of identity.

Here are some examples of the loss of the boundary between self and other:

As noted above, Ms. Williams reported that she feared Dr. C would attack her, and that this coincided with her own impulses to stand up and punch Dr. C. She was unable to discern who wanted to murder whom.

Mr. DeVito heard voices outside his head accusing him of being a gangster. When he was not psychotic, he had repeatedly complained that his aunt had mistreated and abused him. Apparently, when he was psychotic, it was no longer clear who was the abuser and who the abused.

At work, Ms. Chen repeatedly left cryptic messages in the staff mailboxes, in which she made obscure observations about her colleagues. When her symptoms became worse, she believed that it was her colleagues who were cryptically communicating with her by leaving paper cups in certain patterns near the water cooler, and by wearing outfits with special colours.

Another man who was acutely psychotic came to the emergency room and claimed that he was Ted Koppel, J. Edgar Hoover and Bart Simpson all in one. Clearly, his sense of identity was neither well defined nor even unitary.

In terms of object relations, a disturbance in the sense of boundary leads these patients to feel helplessly at the mercy of affects stirred up by another person. People with this kind of boundary disturbance feel that there is nothing to shield

them from powerful longings, disappointments, excitements and losses stirred up by the other person's behaviour. They feel buffeted by these external stimuli, out of control and often that their inner life is being controlled or manipulated by the other. These experiences contribute to a sense of vulnerability to pain initiated by the outside world, and lay the groundwork for organizing experience in a paranoid way. They also have a powerful impact on self-esteem, leading to feelings of helplessness, shame and impotence. Some people with these problems defensively distance themselves from others, making use of paranoid fantasies to justify their isolation. Eventually, for some, this isolation serves only to increase their feeling of loss and disconnectedness. In time, the hunger for contact leads to renewed and more desperate needs for a relationship with the other, and new and more intense fears of engulfment begin (see Chapter 6 on the disturbance in the sense of boundary and its relation to paranoia).

During her psychotherapy, Ms. Chen felt alternately close to and distant from her therapist. When her therapist made a transference interpretation that hit home, Ms. Chen's feeling of being understood was often accompanied by a feeling of being under that therapist's control. At these times, she had the bodily sensation that her therapist was grasping her ear with metal pincers. At other times, when she felt her therapist was too close to her, she had the sensation of feeling somehow shrivelled and smaller, as if her skin were loose like a deflated balloon. Such experiences led her continually to try to reestablish a distance by cancelling sessions, or by perceiving the therapist as an adversary.

The blurring of the boundary between self and other has been emphasized by many authors (Freud, 1914, 1921, 1923, 1925; Fenichel, 1945; Reich, 1954; Greenacre, 1958; Mahler, 1958, 1963, 1968; Lampl-de Groot, 1962; Jacobson, 1967; Greenson, 1968b; Stoller, 1974; Kernberg, 1975; Person and Ovesey, 1978; Bergman, 1982). This boundary disturbance may arise in different ways: from a disturbance in psychological development, from the use of primitive defences or from disturbances in brain development and function such as defects in stimulus barriers.

From the standpoint of psychological defence, patients who experience their affects or self-representations as intolerable may want to believe that it is the therapist who possesses all their unacceptable parts, and may use primitive defences (e.g. projective identification or primitive denial) to attempt to force these parts, in fantasy, into the therapist (Klein, 1946; Kernberg, 1975). As a result, the boundary between self and other may become confused. Or, the patient may seek regressive refusion of self and object images (Jacobson, 1964, 1967) in an effort to establish a safe, stable object relationship that is insured, so to speak, against change and loss. This effort, obviously, can contribute to boundary confusion. Of course, it may be that developmentally, the patient may never have achieved an adequate psychic separation from the parent (Mahler, 1968; Loewald, 1980) (another mechanism for the blurring of the self-object boundary is suggested in Chapter 6). In any event, the tendency to confuse self and object images is a crucial factor in the development of psychotic symptomatology.

4. Disturbance in symbol use

People in psychotic states show a disturbance in the use of symbols in general, and language in particular. One facet of the disturbance in symbol use is the apparent loss of the capacity for symbol and concept formation (abstraction) and, as a consequence, of much of the experience of meaning. Where once concepts and meanings existed, and importantly, the affects that accompanied them (Searles, 1979: 16), new sensations and perceptions spring up instead. There appears to be a kind of de-symbolizing (Searles, 1965), or more specifically, a de-conceptualizing of experience. Instead of thinking, the person seems to be beset by all kinds of uncanny and bizarre somatic, perceptual and sensory experiences. One might speculate that the evolution of conceptual thought from concrete sensation has been reversed (see Chapter 6).

When Mr. DeVito first described what he later identified as sadness, he said that he could literally feel his heart in his chest. He said it was sliding down because it "weighs so much".

When Ms. Chen was criticized by her school principal, she did not report feeling that her sense of identity was threatened, but instead had the physical sensation that her "body had shrunk" and was now "small and painful". The same patient, as noted above, experienced her skin as "loose and shrivelled" when she felt that her therapist has disparaged her. She was not conscious of feeling painfully vulnerable to being hurt by her doctor, or that the doctor had betrayed her budding affection by deflating her sense of her own value, or any other emotion that would have fit the emotional context.

On the other side, certain patients diagnosed with schizophrenia are given to conceptual vagueness and obfuscation. For these individuals, as Freud noted in his discussion of "Words and Things" (1915: 209–15), words seem to have lost their moorings, and no longer are reliable signs that designate an agreed-upon referent. They are like buoys that have broken loose, wandering about in the sea, no longer marking reliable locations in any systematic way. One feels one has lost one's way among vague, stilted and scattered verbal signs. Freud believed that these difficulties in symbol use and language came about because of a disconnection between the symbol (the "word presentation") and the object in the real world that it refers to (the "thing presentation"). He believed that in psychosis, the patient confuses the word (or concept) and the thing.

The conceptual vagueness in people diagnosed with schizophrenia has sometimes been referred to as "overabstraction", but this kind of mental activity is not really abstraction in that no true concept formation (Vygotsky, 1934; Piaget and Inhelder, 1969) or class-concept use (Langer, 1967) is taking place. Many writers have described and theorized about the alternating concreteness and abstractness of schizophrenic speech (e.g. Klein, 1946).

Such verbal productions may be intended more to obscure communication than to advance it. Speech serves to hide as well as to communicate, as Orwell's famous examples in *Nineteen Eighty-Four* (1949) show.

Ms. Williams said as much when she talked about her incoherent orations at activities therapy. In a moment of candour she explained: "When I talk that way in activities therapy it's so no one will know what feelings I'm really having."

If, in fact, symbol use is defective in schizophrenia, then a psychotherapy that depends primarily on interpretation of symbolic expressions, by means of symbols, and that presumes an already well-functioning "symbolic apparatus", is compromised from the beginning. Searles has written, "A patient who is experiencing himself as a shifting flux of somatic sensations, thoughts, mental images, memories and so on is in no condition to hear or utilize a verbal interpretation from the analyst" (1979: 145). It would seem that one of the first orders of business in psychotherapy with psychotic patients should be to address the defect in symbol use (see Naming and Enlargement later in this chapter). Without some improvement in this ego function, the traditional analytic tools of clarification, confrontation and interpretation are robbed of their power.

5. Disturbance in the testing of reality

The breakdown of the capacity to test reality has been identified by most writers as the defining disturbance in psychosis (Freud, 1924a, b; Fenichel, 1945; Kernberg, 1975, 1984). For Kernberg, this ego function consists of the capacity to discriminate internal from external sources of perception, the capacity to differentiate self from object and the capacity to empathize with the social criteria of reality (1975, 1984). I have discussed this in some detail Chapter 1. What I would like to add here is that the ego's capacity to develop a representational world (i.e. a "mind's eye") in turn rests upon the integrity of the ego's ability to use concepts. If symbols and concepts become degraded into their perceptual and sensational building blocks, then the door is opened to confusion about the source of phenomenal experience. Similarly, if the experience of interpersonal influence is de-conceptualized and perceptualized, this may lead to the concrete perception of a lack of boundary between self and object. Finally, if the world of conceptual thought is lost, the individual loses, pari passu, his link to the world of shared cultural meaning. Thus, his empathy with the social criteria of reality is lost. The mechanisms by which de-conceptualization and de-symbolization may compromise reality testing are discussed further in Chapter 6.

The list of ego disturbances discussed above is by no means comprehensive. It does, however, designate a set of dysfunctions that have been identified by a large number of writers from diverse theoretical backgrounds. These disorders may be said to comprise a "core" of ego psychopathology about which some consensus has developed.

General principles of psychotherapy

A psychotherapy of individuals diagnosed with schizophrenia should take into account the pathology of the ego discussed above. It should combine a rational

plan to ameliorate them, as well as an appreciation of how the basic model and methods of psychoanalytic therapy should be modified to work within the limits imposed by these ego modifications.

Before describing individual techniques for psychotherapy with psychotic patients, I would like to emphasize some general principles of technique that are important to keep in mind regardless of one‘s specific intervention.

The importance of putting inner experience into words

Whatever the ultimate goal of treatment, effective psychological therapy will call upon the patient's capacity for verbal symbol use and concept formation. In discussing psychoanalysis as a talking cure, Freud (1916–17) addressed the criticism that the treatment was "only words" and therefore somehow gossamer. He emphasized the power of words, and their influence as agents of change. He went so far as to say that the goal of psychoanalytic treatment was to reproduce the patient's pathological impressions in words, and "the therapeutic task consists solely in inducing him to do so" (Breuer and Freud, 1895: 283). Whether the long-range objectives for the psychological treatment of the patient diagnosed with schizophrenia are symptom reduction or psychic reorganization, the immediate goal must always be to help the patient put his experience into words. Since effective treatment usually requires a long period of time, and since overall success depends so completely on the use of words, this immediate goal, at least at the outset, becomes the *fundamental practical goal.* None of the other therapeutic aims of a verbal psychotherapy, such as affect tolerance, control of impulses or self-understanding, can occur if the patient cannot succeed in putting his experience into appropriate words. This is a necessary, although not sufficient, condition for progress in verbal psychotherapy. Without it, treatment can only consist of changes brought about by medicine, or changes in behaviour caused by manipulative treatments such as operant conditioning, punishment and so on. Thus, in many cases where symptomatic change may be very slow, psychotherapy must address a provisional and more immediate goal: helping the patient to use words.

Monitoring the interpersonal relationship

It would lead us too far from the central discussion to examine here the question of whether a "real" relationship (Greenson, 1968a) exists between a patient and his therapist that is distinct from the transference. Similarly, whether patients are capable of developing a "new" transference, or only repeat infantile experiences, cannot be taken up at length. My own perspective is that it is useful to draw a distinction between the transference and the "interpersonal relationship" between patient and therapist in work with psychotic patients.

First, the distortion of the image of the therapist is not limited to transference of the neurotic type. It depends also on massive disruptions in ego functioning,

some of which are caused by primitive defensive operations such as projective identification, primitive denial and fusion of self and object images. The therapist is not routinely perceived only as a new edition of an actual past object, but often as a figure that is grossly distorted by past and present defences and failures in ego function (Kernberg, 1975). What might be a question of a dynamically motivated substitution of past for present in a neurotic patient (within the bounds of good reality testing) becomes, in the psychotic patient, a frank break with reality. With neurotic patients, patient and therapist can agree that a certain feeling or thought does not rationally "fit" in the present relationship with the therapist, and must therefore represent the effect of an emotion or fantasy based in the past.

With the psychotic patient there is often no such shared, detached viewpoint. In the patient's view, he does not *imagine* that the therapist is dishonest, persecutory, uncaring, controlling or malicious; the therapist *is* these things. If the patient does not agree that a certain emotion is based in transference, one cannot interpret it to him as such. In my own mind, I find it useful to think of such experiences as "interactional" or "interpersonal". I leave the clarification of transference phenomena for later exploration, when the patient is more able to appreciate how his perceptions may be distorted. For the present, I focus on how the patient's beliefs arise from the evidence he has gathered, how these beliefs or this evidence fit with what else he knows, and whether his conclusions develop logically from this information. Helping the patient with his testing of reality proceeds pari passu with this approach. This way of working often involves reviewing, examining and explaining the therapist's view of the interaction with the patient, steps not necessary with patients whose reality testing is intact (see below, pages 84–88 and Chapter 5, pages 94–102).

In work with neurotic patients one might say there is a "neutral" area in which both patient and therapist understand the following: that a doctor-patient relationship has been established, that it involves certain practical financial and schedule arrangements, that patient and therapist have different and well-delineated roles, that they will have little if any social contact, and that the therapist's role is not to become a directly gratifying figure in the patient's life. This neutral area is often invaded and under siege in work with psychotic patients.

Ms. Williams and Ms. Jackson barged in on sessions with other patients (see pages 56–59 and 60–61). Both rummaged through personal belongings in the therapist's office. Patients may try to follow the therapist from his office, or call him at his home, or refuse to leave the consulting room. No doubt, these behaviours are connected to infantile transferences. But the boundary between what is the patient and what is the therapist has been so abridged, the capacity to empathize with the therapist's role so compromised, the use of primitive defence and the operation of pathological ego functions so widespread, that it is hard to conceptualize these behaviours as straightforward repetitions or faithful replicas of developmental experience. Moreover, it is usually futile therapeutically to link such behaviours with past experience. Since the patient does not acknowledge that

his own distortions based on the past may be playing a role in his relation to the therapist, I find it useful to think of these experiences as "interactional", focusing on the here-and-now.

Finally, I would like to make what may be an obvious point. Work with patients diagnosed with schizophrenia often involves more activity and actual self-revelation on the part of the therapist than with neurotic or borderline patients. One can reasonably assume then that at least some of the patient's reactions to the therapist occur in response to emotions and ideas the therapist expresses, and actions he takes.

One of the major causes for failure in psychotherapy with psychotic patients is the inability to establish a working relationship. The patient flees from treatment because of real or imagined qualities of the therapist. Introspection and self-disclosure will never occur without some rudimentary belief in the therapist's honesty, dependability and self-control. The therapeutic alliance or "pact" (Freud, 1940) depends on such a groundwork, and everything that might interfere with it should be carefully monitored. The patient, for example, may be offended by the therapist's mood or tone. He may be angry about a rescheduled meeting, or the denial of a request. The therapist must ask himself constantly: what kind of relationship do I have with the patient now? Does he feel spiteful? Is he envious? Does he feel hurt? What behaviour of mine might have triggered these feelings, or might intensify them? How will these feelings influence the patient's willingness to put his thoughts and feelings into words?

Monitoring the transference

What I have said above does not mean that the therapist should not be alert to the repetition of past object relations in the present. All phenomena, verbal and behavioural, in and out of sessions, must be considered in the light of their relationship to the therapist and their historical meanings. For patients diagnosed with schizophrenia, who may at times experience emptiness interpersonally and intrapsychically, the relationship with the therapist can assume enormous importance. Negative transferences based on past object relations can have a particularly destructive impact on the treatment alliance.

Ms. Chen, the middle-aged teacher, was extremely concerned that greater closeness meant that the therapist would manipulate her. It was very important to her sense of psychological integrity that she maintain her "personal space".

One could well understand her concern in terms of her impaired sense of boundary, her wishes for and fears of fusion, and her use of primitive projection. Nevertheless, it was also the case that Ms. Chen's mother had been shockingly intrusive during her childhood. Despite her daughter's passion for swimming, her mother pressured her to discontinue participation in after-school athletic activities. She repeatedly gave heavy-handed direction about her studies and friendships. She even called the parents of her daughter's friends to push her daughter in what she felt was the right direction.

Monitoring the countertransference

A variety of authors, with different theoretical points of view, have observed that countertransference reactions can provide essential information about the subjective state of the patient. As used in this sense, the term *countertransference* refers not to the therapist's idiosyncratic image of the patient as a current version of an object from his own past, but rather to the thoughts, feelings and impulses that occur to him as he responds to what the patient says or does. Arlow has written about such reactions in psychoanalysis: "No matter how distant the context of his thoughts may seem from the patient's preoccupations, he (the analyst) nevertheless appreciates them as clues or signals pointing to the unconscious meaning of the patient's communications" (1980: 204).

If attention to this phenomenon is important in work with neurotic patients, then it is indispensable in work with psychotic patients. Rosenfeld (1952) has written that such countertransference reactions are often the "only guide" to what is happening with a chaotic or uncommunicative patient. Because the patient's capacity for symbolic communication is frequently impaired, voluntary verbal communication may be impossible. The more such communication breaks down, the more it seems that the patient relies upon inducing emotions and thoughts in the therapist by nonverbal means (Lotterman, 1990), and the more vital it is that the therapist makes use of his own capacity to be a "receiving set" (Freud, 1912; Rosenfeld, 1952) for such signals.

Respect for psychic determinism

Freud (1916–17) emphasized that seemingly bizarre or incomprehensible behaviour or mental events had a "sense". This awareness is no less important in working with psychotic patients than it is with neurotic patients. In fact, it is perhaps more so, because thought and behaviour in patients with schizophrenia can appear so much more "senseless" and so much more difficult to comprehend than that of neurotic patients. Often, patients cannot even produce sensible rationalizations for their symptomatic behaviour as neurotic patients can, adding to the impression of its senselessness. In any case, there is a greater prejudice among clinicians against seeing the sense behind psychotic symptoms, especially when those symptoms cause disruptions in the process of verbal communication. In practice, loose associations are rarely viewed as symptoms with a sense, but rather are seen to be evidence of a neurochemical or neuroanatomic diathesis. Again, I am not attempting to discount the relevance of somatic or genetic factors in schizophrenia. I am saying that even in the case of such dramatic symptoms as looseness of association, concreteness of thought, auditory hallucinations or paranoid delusions, it is profitable to consider that the patient's acts or thoughts, though bizarre, may have a sense or may communicate something important. While there is no guarantee that this approach will always bear fruit and always uncover hidden meanings, such meanings can never be found without the commitment to search for them.

Dorothy Bender, a 40-year-old woman, had a long-standing history of paranoid delusions, auditory hallucinations, social isolation, idiosyncratic and bizarre behaviour and marked disturbances in thinking and speech, but no history of prominent affective symptoms or organic pathology. Her diagnosis was schizophrenia according to DSM-IV TR criteria and she was psychotic by Kernberg's structural criteria as well. Early in one session, Dr. M asked her what had led to her troubles with her family, with whom she had fought a great deal. After fending off this question several times, she said that she saw something blurry and indistinct next to Dr. M's chair. Dr. M asked her about it and she appeared uninterested and otherwise preoccupied.

Dr. M decided to persevere, and asked her to describe in as much detail as she could what the object looked like, how big it was, what shape it seemed to have, what the surface appearance was, and so on. She said that it seemed to become clearer and looked like a scouring pad. Its surface looked rough and abrasive. "It has the appearance of someone who is irritating and pushy." This opened up a discussion of how irritating and grating it was that Dr. M continued to probe about her family conflicts, which Ms. Bender did not want to discuss. What appeared from one point of view to be an irrelevant and bothersome sensory malfunction turned out to have a lot of meaning.

Parameters of technique

In discussing the psychoanalytic treatment of certain patients Eissler (1953a) suggested that departures from the basic model technique of psychoanalysis might be necessary. He termed such technical departures *parameters of technique* and suggested guidelines for using them. Historically, one purpose of these modifications has been to limit the unproductive acting out of certain patients. Kernberg (1975, 1984) has made the use of such parameters a building block of his technique with severe character disorders. It is outside the scope of this work to discuss whether such parameters represent a departure from psychoanalytic treatment. My own view is that they are compatible with psychoanalytic therapy. In any case, the psychotherapy of people diagnosed with schizophrenia usually cannot occur without such parameters, at least at some point.

Psychotic patients, even more than borderline patients, can be impulsive, provocative and destructive of their treatments. Parameters may consist of rules concerning behaviour in and out of the sessions, and they serve several functions. First, they can serve to protect the therapist's technical neutrality so that, for example, he does not become too intimidated or too angry. Second, they prevent the patient from destroying conditions necessary for a successful therapy by such means as self-cutting, manipulative suicide attempts or attending sessions while intoxicated. Third, they can be designed to limit the gratification rather than the verbal working through of primitive impulses. As I discussed in Chapter 3, refraining from responding to blatant provocation and destruction of the treatment setting by such activities as yelling, touching the therapist or destroying

property is to permit the pathology of the patient to triumph. Listening inertly in such circumstances is not technical neutrality, but may be closer to denial, reflecting a fanciful wish that the disorganized or out-of-control patient will, somehow, on his own, come to his senses.

Theoretically, parameters include any temporary modification of standard psychoanalytic technique designed to assist in the development of a psychoanalytic process. Certainly, one of the most important parameters is the setting of limits. A number of examples were given in Chapter 3, and will not be repeated here. Many of the specific techniques I will now discuss, such as disclosing induced emotion, self-disclosure as part of object definition, naming, enlargement and role-playing, fall into the category of parameters of technique. One may argue that these techniques do not keep the modification of psychoanalytic therapy to "a bare minimum" (Eissler, 1953a), that with psychotic patients they are used over long periods of time, and that, in the end, they may not be resolved by interpretation. Nevertheless, they are designed to increase the chance that a psychoanalytic process will develop, based upon the uncovering and interpretation of unconscious thoughts and feelings arising out of the relationship with the therapist. They may also be essential in approaching resistances to psychological therapy that strictly verbal approaches have not succeeded in addressing. Parameters of technique are designed to facilitate, not replace, the psychodynamic process. In some cases, when the patient is better able to identify and report his inner states in words and concepts, the use of these parameters becomes less imperative.

Specific psychotherapy techniques

Object definition

In the basic model technique of psychoanalysis (Eissler, 1953a), the analyst remains a relatively dim, poorly defined figure. This permits regression in the patient and a more rapid, full-blown transference to develop. While neurotic patients with intact reality testing can make creative and adaptive use of this regression as a source of information about themselves, borderline patients often cannot do so, and are vulnerable to confusing transference and reality; that is to say, they may experience a transference psychosis (Rosenfeld, 1952; Little, 1957; Searles, 1963; Kernberg, 1984). Patients diagnosed with schizophrenia are more vulnerable still. They have a very difficult time distinguishing between the therapist as a transference figure and as a real object. Little (1957) has called such transferences "delusional". Part of the basis for the changing and inconstant object images of the therapist has to do with the patient's tendency to fuse self and object representations, and to use primitive forms of projection that blur self and object boundaries (Kernberg, 1975). It is unclear who is the patient, who is the therapist and what belongs to each.

Some writers have suggested that one must not confront the psychotic patient with his delusional perceptions, if at all possible (Walder, 1925; Clark, 1933;

Balint, 1959; Spotnitz, 1969). Balint has written that the therapist "should not be an entity in his own right . . . in fact, not a sharply contoured object at all, but should blend into the friendly expanses surrounding the patient" (1959: 97). The aim of this blending in is to form a "narcissistic alliance" with the patient and to gradually "draw the patient out" into the object world.

With psychotic patients this strategy is often impossible if not counterproductive. Precisely because of the patient's ego modifications and primitive defences, he often cannot make use of direct support. His mistrust and envy (Klein, 1957) spoil incoming nourishment; as often as not, the patient sees attempts at support through paranoid lenses: food becomes poison.

Moreover, at least partly because certain psychotic defences (e.g. fusion of self and object representations, projective identification, psychotic denial) disrupt ego functioning, reality testing breaks down. To preserve reality testing, and to reverse the effect of these pathological defences, it is important that the therapist be very precisely "contoured". Psychotic patients often need a sharply and clearly defined object as a model, and as a kind of trellis against which to develop. The therapist's remaining indistinct and shadowy often leads to confusion and frustration. In any event, many patients will simply continue to press the issue of the patient-therapist boundary until it is either clarified constructively, or the treatment breaks down.

Ms. Williams, the young woman from the inner city, was in Dr. C's office and, again, tried to unplug the telephone and answering machine.

Dr. C: *In my office, you behave as if my things are your things. As if my office and body belong to you. If I stop you, it upsets you and you begin to feel some kind of pain. But if I don't, I feel pain because you act as if what is mine belongs to you. You want to block out your suffering by being a clown with me. You feel better if you make our relationship into a joke, and block me out.*

Ms. W: *With my family, I did the same thing.*

At this point, Dr. C explained to the patient that they would hold their meetings on the inpatient unit and not in her private office, and that she would ask a staff member to observe them, if Ms. Williams could not refrain from disrupting sessions.

Ms. W: *You're saying that John and Robert (members of the staff) will be in session with us?*

Dr. C: *Yes.*

Ms. Williams leaned back, smiled, and then got up to unplug the lamp.

Dr. C: *When you act this way, I take it to mean that you want to destroy me, my office and the treatment. Maybe you wonder why I sit here calmly, while*

you try to destroy me. Maybe you wonder if I'm crazy or if I want you to hurt me. Well, I don't want you to hurt me, and I'm not crazy. From now on, we'll have to meet on the unit, not in my private office anymore. If I have to, I'll ask the staff to join us so we'll both know that you won't be able to harm me or my things.

In this example, Dr. C set a limit with the patient specifically related to the location of the boundary between them. Dr. C did not allow Ms. Williams to continue to invade her privacy or destroy her property. Dr. C presented the patient with a "sharp contour" in relation to which she could learn more about her therapist and herself. Clearly, Ms. Williams pushed Dr. C to the point where it was impossible for her not to do this. I think that many psychotic patients need the therapist to define his identity in certain areas to begin to define themselves, and often force the therapist's hand in this direction.

Sometimes, becoming a defined object involves sharing feelings with the patient.

Ms. W: *I'm frightened. Sometimes I think of beating my sister with a rock. Or of shooting my brother. If a pulled a gun on you, would you be frightened?*

Dr. C: *Yes.*

Sometimes, realistic acknowledgement of the patient's effect on one's feelings clarifies the boundary between patient and therapist, and can facilitate the patient's expression of feeling.

Ms. Williams had talked incoherently for quite a while, but finally was speaking in a more direct and poignant way about her sadness.

Dr. C: *You know, when we talk together, I feel upset. When you tell me your feelings, I feel sad. Even though it hurts sometimes, it's a lot better than when you were out of control and making a joke out of our relationship. Now, when you talk, it makes sense to me. How do you feel about it?*

Here is another example:

Mr. DeVito had spent months in the treatment acting as if he were formless and without an identity.

Mr. D: *You know, when I walked in today, I thought I saw you looking out the window with a sad and forlorn expression. I thought at first that I must be mistaken. That you couldn't be feeling that way.*

Dr. B: *Why not?*

Mr. D: Because you seem like such a together person. It just didn't seem to make sense that you were feeling sad. But I also thought, if he feels that way sometimes, maybe he could see what I'm going through. Was I right? Were you sad?

Dr. B: I think you did pick something up. There have been some unhappy things that have happened to me recently, and I guess it shows up on my face. What you picked up was accurate.

Mr. D: I feel like a human being.

Dr. B: How so?

Mr. D: Like I can talk about feelings like a real person, and that I know what's going on.

Mr. DeVito went on in the session to discuss feelings of emptiness and isolation from others.

Part of the value in selectively expressing one's opinions or feelings to the patient is that it can help him to evaluate the accuracy of his testing of reality. In this case, Mr. DeVito did correctly identify the mood that led to his therapist's sad expression. To acknowledge this to Mr. DeVito, whose reality testing was often impaired, not only did no harm, but helped him to develop confidence in his capacity to observe and understand others. Not to have acknowledged the correctness of his perception would have been to have lost a chance to confirm his capacity for empathy.

Emotional induction

Awareness

Scores of psychoanalytic writers have discussed the nonverbal process by which the therapist's emotions resonate with the subjective emotional experience of the patient, even though these feelings may not be in the patient's awareness. Such therapist *countertransference* reactions may yield insight into the patient's mental life that can be gained in no other way (Steiner, 1993). Beginning in the early 1950s and continuing to the present, clinicians have increasingly appreciated the importance of countertransference. Little (1957) specified a group of patients who characteristically communicate by stirring up emotional responses in the therapist: psychotic patients, patients with severe character disorders, patients with psychosomatic conditions and patients who have difficulty putting thoughts and feelings into words.

My impression is that there is an inverse relation between the patient's capacity to identify and communicate inner emotional states and his use of nonverbal methods to convey his feelings. I have referred to this nonverbal form of communication as "emotional induction" (Lotterman, 1990). It is as if the less the patient is able to use words as vehicles to transmit meanings, the more he relies upon this nonverbal inducing of emotions to communicate with the therapist.

In psychoanalytic therapy with neurotic patients, the therapist's use of his own emotional reactions to guide his understanding of the patient can complement his cognitive insight. In work with patients diagnosed with schizophrenia, these therapist reactions are indispensable and may be the only way the patient's inner life can enter the treatment at all. Such patients may talk little or do so in largely incoherent or disconnected ways, leaving the therapist few verbal clues as to what is going on. However, a patient often will act in a way that evokes in the therapist the patient's disowned feelings.

In work with patients who are neurotic, one feels one's attention directed to ideas and feelings that, phenomenologically, feel "over there", somehow psychologically localized near the patient. Whether it is an emotion, a fantasy or a thought, it is as if one is a member of an audience watching the action on a separate stage. One has the psychic room to reflect, to muse, to allow one's mind to wander. One feels emotionally responsive, but not immediately involved in the action. In other words, there is some emotional distance.

In work with borderline patients, and especially psychotic patients, the "location" of the action of the treatment often feels very different. One frequently feels that psychological phenomena, often intense and disturbing, are "over here", inside oneself, while the patient remains calm, unperturbed and unreflective. It feels as if one is no longer watching a drama at leisure. Rather, one feels that the actors have come down off the stage and have drawn one into the performance. As might happen in the theatre, if, for example, a comic draws one into the act, one feels as if the action is going on not "over there" but "over here", all around and inside oneself. It is by translating this intense emotional experience into words and concepts that the therapist may come to understand more about the transference.

Example: Ms. Williams – confusion induced in the therapist

Ms. Williams, whose antics disrupted her sessions with Dr. C and led Dr. C to bring staff members into their meetings, had been trying, once again, to put on Dr. C's coat and unplug her answering machine. One day, Dr. C was feeling particularly intruded upon and helpless. She felt that her privacy had been invaded and that everything was topsy-turvy. As she was just coming to recognize these feelings during a session, Ms. Williams said: "You're trying to drive me insane. You want to make me all confused." Apparently, with her unpredictable antics, Ms. Williams managed to induce very similar feelings in Dr. C about her.

On another occasion, Ms. Williams had kept Dr. C waiting at a time when they urgently needed to talk.

Dr. C: *I feel frustrated. I was eager to start our session, but I felt I didn't have control over when you'd get back here.*

Ms. W: *Control is something I never have here. Patients on this unit never have a say over anything. Now you feel some of what I go through every day.*

Example: Mr. DeVito – passivity induced in the therapist

Mr. DeVito, the man beset with the gangster, had few thoughts, feelings or wishes for months. His therapist and he had spent many sessions together with seemingly very little of value going on. The therapist felt torpid, useless and that his identity as a professional had dissolved. He felt uncomfortably formless and passive. Since this had become such a powerful part of his experience with Mr. DeVito, and since he had few other clinical clues to help him understand what was going on, the therapist shared this reaction with the patient.

Dr. B: *I want to let you know what I'm feeling. My feelings may tell us something about what's going on in you. Sometimes when we meet I feel very tired and slow, like my mind is in a fog. I feel like my mind has shut down, that my thoughts and feelings are empty and sometimes I can't remember what I'm supposed to be doing here. At times, I feel like sitting back and daydreaming, hoping that nothing interrupts it. It feels cosy and blank.*

Mr. D: *I feel like that all the time.*

Mr. DeVito went on to talk about how he felt like a "lump" and had no clear sense of his own identity or value. He expressed anger at the therapist for describing how he felt, and for giving up on him. He understood the purpose of Dr. B's remarks, however, and over the next several weeks was able to explore his feelings of worthlessness, passivity and emptiness. Considerable behavioural change also followed.

Later, I will discuss in more detail the value and timing of sharing induced emotions with the patient, but here, I would like to emphasize how Mr. DeVito had managed to convey a very complicated experience to the therapist without the use of words. Moreover, the therapist's grasp of Mr. DeVito's emotional situation was not an abstract one. He had an immediate experience of what worthlessness, formlessness and emptiness meant for the patient.

Mechanism

Despite the fact that so many writers have discussed the way in which the patient's emotions are communicated via the "total" countertransference (Kernberg, 1975, 1984), many authors remain puzzled about how this actually occurs. Fenichel wrote, "We know nothing about the specific nature of this identification" (1945: 84). Sullivan (1962) wrote, "The rationale of this induction—that is, how anxiety in the mothering one induces anxiety in the infant—is thoroughly obscure." Kernberg noted, "We probably still do not know enough about how one person's behavior may induce emotional and behavioral reactions in another" (1984: 123).

A number of clinicians have turned to the concept of "projective identification" as an explanation for the way in which the patient's feelings appear to be induced in the therapist. There are several problems with this explanation. First, the term

projective identification is used so variously that few agree on a precise meaning. Originally (Klein, 1946), it referred to an *intrapsychic fantasy* in which bad parts of the self were split off and, in fantasy, forced into or coming from another person. The term did not have an interpersonal dimension until Bion (1956) described the way in which the patient would so treat the therapist that the latter became a "container" for the patient's fantasy, and somehow came to experience some of the fantasied contents himself. Still later, the term was used rather promiscuously, and came at different times to refer to a fantasy, a defence, an object relation, a mode of communication and a pathway for change (Ogden, 1979). Kulish wrote of the term's ambiguity and overinclusiveness: "To ask a concept to be a fantasy, a defense, and an object relationship, is to ask it to do too much" (1985: 91). Because projective identification has lost much of its conceptual clarity, its value as an explanation has been undermined.

The second problem with explaining induced emotion by means of projective identification is that no explanation has really been advanced. The term is invoked, but it is not clear what the mechanism of this interpersonal process is. What does one person actually do to another to evoke particular feelings and fantasies? How is emotional experience transmitted between two people without the use of words? How can such communication occur unconsciously?

I would like to propose the following explanation, which I have described in much greater detail in an earlier paper (Lotterman, 1990). Both Bion (1959) and Searles (1979) have described the way in which patients can purposefully, even if unconsciously, play upon the therapist's feelings. In particular, Searles noted that some of his patients felt that their parents had tried to communicate their own internal states by putting them in certain similar, real interpersonal situations. These patients believed that their parents were intentionally communicating to them in this way.

I believe that a mechanism such as this occurs frequently in psychotherapy. Patients behave in characteristic ways that are designed to generate predictable emotional reactions in the therapist. The process is similar to that used by actors when they wish to produce predictable dramatic effects in their audiences. Hamlet berated Guildenstern for playing upon him in just such a way.

> You would play upon me, you would seem to know my stops, you would pluck out the heart of my mystery, you would sound me from my lowest note to the top of my compass; and there is much music, excellent voice, in this little organ, yet cannot you make it speak. 'Sblood, do you think I am easier to be played on than a pipe?
>
> (*Hamlet*, Act III, Scene ii)

Skilful playwrights know that intellectual speeches do not generate intense emotions in the audience. They *arrange* sequences of actions, words and expressions to generate expectable emotional responses. T. S. Eliot wrote in *Hamlet and His Problems* (1919), "The only way of expressing emotion in the form of art is by finding an 'objective correlative'; in other words a *set of objects, a situation, a*

chain of events which shall be the formula for that *particular* emotion" (quoted in Bartlett [1980: 809]; emphasis added).

When Ms. Williams said, "Now you feel what I feel", I think she was acknowledging the fact that she had put her therapist in an emotional position similar to her own, and that as a result Dr. C had come to feel what it was like to be her. In the examples described above, the patients used techniques and tools similar to those used in the theatre: *mime*, *stage management* (the sequencing and location of action), *delivery* (consisting of *timing* and *tone*) *costume* and *props.* All these nonverbal techniques helped to provoke, arouse and stimulate feelings and thereby add force to the emotional position the patient was trying to impress on the therapist.

One might say that such *induced emotion* is the executive arm of projective identification defined strictly as a fantasy. When induced emotion occurs together with fantasies of entry and control (Klein, 1946), it can mould the external environment in the image of the internal, so that the individual's interpersonal world has been altered to resemble his fantasies.

Disclosure

How does one make therapeutic use of emotions induced by the patient? Some authors advise against disclosing feelings to the patient under all circumstances (Heimann, 1950), and simply suggest that the therapist use this countertransference information as part of his general store of knowledge about the patient. I believe that disclosing one's emotional response can be very useful with psychotic patients, if one's personal reactions and responses are carefully monitored. As I have discussed in the sections on parameters and object definition, sharing one's reactions with the patient is often an essential aspect of setting needed limits. Beyond this, however, a patient may act in such a way toward the therapist as to induce reactions that can seem improper or unseemly to discuss with the patient. The therapist may feel disgusted by the patient, revolted or contemptuous. He may feel sadistic or enraged or loving or longing. Much psychotherapy training teaches us not to communicate such feelings for fear of burdening or confusing the patient.

In work with patients, however, the therapist's reaction is often the first, if not the only, way for essential transference material to enter the treatment. The example of Dr. B's discussion with Mr. DeVito was such a case. It is as if the therapist were the patient's auxiliary ego, with the following distinct functions: affect tolerance, affect recognition, concept formation, symbol (word) selection and communication. The therapist thus becomes the integrator, concept former and communicator of the feelings that the patient has induced in him. To *not* communicate these emotions, at times, is to be drawn into the patient's resistance to these affects. A sophisticated, even if seemingly disorganized, patient may use his therapist's professional reticence to act outrageously toward him, and this may serve as a haven for resistance (Freud, 1916–17). Such emotions either become

lost or are so attenuated by euphemistic references to them that they have no mutative therapeutic effect.

Patients often rely on their own denial of internal and external reality, primitive projection and de-symbolization (Searles, 1965) to keep ideas and feelings from registering emotionally. Patients may also use the therapist's verbal restraint, based on a desire to remain "neutral", "abstinent" or "tactful", as an ally to exclude ideas and feelings that need to be discussed openly and understood. The patient's exposure to a reasonably well-integrated ego such as the therapist's can help him discover in what way he is similar to others and different from them. It can help him distinguish between what is inside and what is outside, what is self and what is other (Kernberg, 1975). Thus it can be a powerful catalyst for the growth of the capacity to test reality.

The therapist's disclosure of his own reactions is often very important in establishing a positive interpersonal relationship—the "pact" that Freud spoke of. For patients who have little experience in connecting feelings to thoughts and thoughts to behaviour, and who use various disintegrative mechanisms to fend off the emotional meanings that occur when such connections are made, it is important to encounter another person who makes such meaningful links. This does not mean that the therapist must disclose material about his personal past, although at times, as in the example of Mr. DeVito, this may be helpful, if the therapist is comfortable doing so. It does often mean that the therapist may say what is on his mind, especially as it relates to the treatment setting.

In addition, it is important to keep in mind that one's emotional response to the patient is not always generated by one's own unique emotional makeup. The behaviour of some patients would stir up a similar emotional response, for example anger, in any "average expectable" observer. Winnicott coined the term *objective countertransference* for such expectable reactions to the patient. If this is so in any particular case, it is very important that the patient understand his impact on the feelings and attitudes of others. Disclosing induced emotion can help in this process.

Several objections might be made to sharing one's emotions with the patient, especially if he is psychotic. Won't the patient feel burdened by hearing about the therapist's inner life? Won't the patient take these emotional expressions literally and feel that he is the "real" object of the therapist who hates or loves him? Won't the patient feel that the therapist has forsaken his "objective" therapeutic role? In work with psychotic patients, won't disclosing induced emotions that seem magically to cross over from one person to another serve to erode the boundary between therapist and patient, a boundary that above all should be clear and distinct? While all these concerns are legitimate and understandable in theory, they are not borne out in practice.

Occasionally, a patient may have a strong reaction to the therapist sharing his feelings. When I told one patient that I felt "overwhelmed", she worried that she had burdened me. Another woman felt that she had hurt me, or that my telling her that I felt "confused" meant that I wanted to get rid of her. When I explained

that the reason why I was telling her about my own feelings was because these reactions might be signals telling us about her emotional state, the patient was well able to understand and work productively. It is often useful to explain the purpose of disclosure to the patient in advance.

Should the therapist be completely "candid" and "honest" about all his reactions? If he feels contempt, disgust, fear or sexual arousal, should he share these reactions with the patient? If so much emotional information enters the treatment via the countertransference, and if attention to the interpersonal relationship is so vital, can one afford *not* to share these feelings with the patient?

As a practical matter, I think, the answer to this last question is yes. To begin with, when emotions first come into the therapist's awareness, it is not clear what they signify. Annoyance or disgust, for example, may be defensive against growing affection for the patient. The therapist's reactions must be understood before they can be disclosed in a therapeutically useful way. Also, a particular countertransference affect or thought and its transference implications may not be the most salient material at that point. At times, the therapist's responses, even painful ones, may be essential to introduce, but the ultimate criterion for doing so is whether this will be therapeutically useful.

Moreover, the therapist is not free of the obligation to consider whether his "induced emotions" actually reflect emotional reactions based on his own past, and not the patient's. I think that with a reasonable degree of self-awareness, though, the therapist can distinguish between what belongs to him and what to the patient.

Example: Ms. Jackson – therapist disclosure reinforces the courage to be honest and face painful emotions

Ms. Jackson was a woman in her early twenties who lived with her aunt and uncle, the Tafts. She had extremely poor impulse control and spent hours hanging around the town park. After a great deal of discussion and painstaking negotiation, her therapist and she agreed that she would take medication for her psychotic symptoms. She reported for over two weeks that she had faithfully followed the treatment plan. Her therapist then learned from her family that Ms. Jackson had lied about taking her medication, and in fact had taken none. This development had been preceded by an episode in which the patient had taken a journal from the therapist's hallway closet.

Dr. S: *I want to talk with you about your not taking the medication we agreed on. It makes me very angry.*

Ms. J: *I know, I know (as if to brush it aside).*

Dr. S: *What I'm going to say you may be able to guess already, but I think it's good to say it directly to you. Being silent about this, and keeping my feelings in, are not going to help. I don't want to put you down, or attack you, but I do want to let you know what I'm feeling. When you took my*

journal from me, I felt you were saying that you didn't respect me or my feelings. I do my best to respect you and what you're telling me, but I felt like you were saying that my feelings don't matter to you and it made me angry. In this situation, when I found out that you weren't taking the medicine, but were telling me that you were, it seemed you didn't care if you told me the truth or not. I said to myself "I'm trying to be honest with her, and to help her as best as I can, but she thinks so little of me, she doesn't even bother to tell me the truth." Do you see why I felt this way?

Although Ms. Jackson initially did not want to discuss her stealing and lying, the therapist disclosing her feelings did bring them into focus. She and her therapist were able to go on to discuss her anger, devaluation and sense of helplessness that anything, whether medication, job training or psychotherapy, could help her feel better.

Example: Ms. Williams – therapist disclosure provides access to the patient's emotions

Over a number of months, Ms. Williams had begun to participate well in her psychotherapy. Her former provocative antics had subsided, but Dr. C had recently told her that she would be graduating from her training programme, and so would leave the unit for another position in the hospital. In the wake of that announcement, Ms. Williams missed several sessions. When Dr. C and she met, Dr. C asked her about the connection between her absence and her feelings. Dr. C commented that perhaps Ms. Williams had missed the sessions because it would stir up painful feelings about Dr. C's leaving the unit. She shrugged off both Dr. C's comments and remained mocking and uninterested.

Dr. C: *I want to tell you something. I actually felt relieved when we didn't meet. Thinking it over, why might I have felt relieved?*

Ms. W: *Maybe you were busy. Maybe they wanted you over in the nurse's station. Maybe you didn't want to see me.*

Dr. C: *Well, the real reason is because talking about stopping our sessions makes me feel sad. It is painful to think about. And sometimes, I guess a part of me would rather not think about it, or feel it, so that I don't have to feel so upset. But that's only one side of me. The rest wanted to meet with you and talk about what is going on between us. That part of me was unhappy that we didn't meet.*

Ms. W: *When you go I'll feel alone and sad. They'll want to give me a new therapist. But it won't be the same. I don't want someone new. I just want to work with you.*

Ms. Williams had begun the session with a flippant nonchalance. She was not willing to put her emotions into words, and did not respond to the therapist's

cognitive linking of the missed session and her being upset. However, it seemed to Dr. C. that when she described her own emotional reaction, which was so similar to the patient's, it was more difficult for the patient to remain flip and detached.

Sometimes the emotion induced in the therapist reflects the patient's feelings about some important figure in his life. Here is an example from work with a borderline patient.

Example: Mr. Martin – therapist disclosure leads to patient's self-reflection

The patient, Richard Martin, had been talking about how unhappy he was in life. He was particularly upset with his girlfriend, whom he described as an irresponsible woman who always got herself into jams, and who expected him to bail her out. He complained that she never took the responsibility for making changes. Mr. Martin went on to say how he had been telling all his friends how bad his life was, while actually doing very little to help himself.

Mr. M: *Everything sucks. I was telling two guys on my softball team, Daryl and Howard, about how everything is falling apart.*
Dr. R: *What made you tell them about it?*
Mr. M: *I don't know.*

There is a pause, while the therapist thinks about this.

Mr. M: *It's almost like I'm waiting for you to say something to make it all better. I feel like a little bird with its mouth open for food.*
Dr. R: *What's that like?*
Mr. M: *It makes me feel fragile, and lost.*
Dr. R: *You know, I'm feeling as if I have to do all the work. And also annoyed. It feels like all these things are happening to you and that you're not willing to make an effort for yourself.*

Mr. Martin thinks for a while.

Mr. M: *I feel just the same way with Caroline, my girlfriend.*
Dr. R: *You keep on rescuing her every time she gets herself in a jam. How come?*
Mr. M: *I don't know. Maybe I feel powerful if I can make someone else feel guilty or responsible for me and then get them to take care of my problems. Maybe I feel that if I'm in pain, I have the right to demand that people bail me out. And that's better than solving my own problems. I guess that somehow, I let Caroline do this kind of thing to me.*

Example: Ms. Weiss – therapist disclosure models self-revealing

When the therapist discusses his own emotions, especially painful or powerful ones, this can help the patient to understand that feelings are not necessarily as dangerous or overwhelming as they may first seem. Most psychotic patients are frightened of their affects. A patient hearing the therapist discuss his own feelings can demonstrate that it is possible to feel, contain and verbalize emotion. In this regard, the therapist's disclosure serves as a model.

Here are two very brief vignettes about Ms. W:

Ms. W: *Sometimes when we meet I feel uptight, nervous.*
Dr. C: *Sometimes I feel uptight and nervous too.*
Ms. W: *How come?*
Dr. C: *Because sometimes I don't know what's going to happen between us. How you're going to act, or whether you'll make a joke out of everything, or even if you're going to come.*
Ms. W: *Well, I guess everybody is nervous some of the time.*

In another session, Ms. Williams, again, was angry at her therapist for leaving the unit. She said that she was afraid to talk about her feelings. Dr. C and she talked for a while about her fear.

Then Dr. C commented:

Dr. C: *You know, I had the same reaction when we began working together. When you were reaching for my clothes, and unplugging the lamp and the answering machine, I felt angry but I kept it in because I thought that afterwards, you wouldn't want to speak with me. I was nervous about that. After a while, I began to think more clearly. But it wasn't easy for me.*
Ms. W: *To tell you the truth, I feel like you're walking out on me, by changing jobs. Like everyone does.*

Sharing emotional reactions with the patient does not necessarily involve painful or unpleasant feelings.

Deborah Weiss, whose apathy, lack of energy and poverty of affect were almost unbudgeable, brought a book of quotations to her session. She read a very poignant quote from Robert Frost on the need for love. Her reading sent chills through Dr. E, her therapist. Dr. E's eyes filled with tears. Dr. E told the patient about his reaction, and this led to a discussion of how emotionally dead Ms. Weiss felt, and of her fears of feeling. In the sessions that followed, she was more expressive and responsive.

Naming

Since all verbal psychotherapy rests on the patient's capacity to use words, the disturbance of symbol use is a particularly debilitating problem. When thought is

incoherent and language use fragmented, there are no vehicles to carry emotional meaning between the patient and therapist. Two related techniques are designed to address this problem. Over a period of time they seem to promote change in the thought and language disturbance of psychotic patients.

Many of these patients have trouble putting their thoughts and feelings into words (Little, 1958). When asked how they feel, many patients say that their minds are blank. Some answer with concrete or somatic imagery: "I'm tired"; "I have a headache"; "My body is changed". Some produce a solitary word such as *awful*, underneath which sits a continent of affect and thought. Ms. Weiss said that her emotions were "too submerged, too far underground" to utter. Ms. Bender said that it was "tough to get a hold of an idea and bring it to my lips". (In Chapter 6, I will suggest some ideas about why there is a disconnection between verbal symbols and affect.)

The technique of naming consists of a systematic, persistent and, at times, meticulous focus on the patient's choice and use of words. The patient may allude to an affect indirectly. Or, it may seem to the therapist that an affect would fit in a certain context, but is absent from the patient's account. The therapist may ask the patient how he feels, and is not deterred by the patient's "I don't know" or "I can't think". The patient may be at a loss for affective terms for his inner states and, at the outset, may only offer descriptions of physical sensations. That is a start. Instead of loneliness or loss, the patient may feel queasy, or have a lump in his throat. Instead of feeling humiliated and that his self-image has been injured, he may feel that his appearance has been changed. In place of feeling manipulated by the therapist, he may have the sensation of something tugging at his neck.

Each description, if it is noted, and if the patient is encouraged to expand upon it, can lead to further associative links. At first, these may remain concrete and somatic. Nevertheless, this can be productive as long as the patient begins to learn and practise the process of connecting words (no matter how poor their initial accuracy) with internal states. Often, a patient who begins by describing a physical sensation can eventually identify underlying emotions.

Example: Ms. Williams – applying words to feeling states

Ms. Williams had just returned from the funeral of a relative. She cared for this woman, and Dr. C assumed that she would feel sad.

Ms. W: *We went to the funeral. I saw her and felt a heavy feeling in my heart.*
Dr. C: *If you were a movie director, and I was an actor, and you were trying to help me feel what you feel, what would you say?*
Ms. W: *I'd say you'd have to have tears in your eyes, and you'd have to cry and feel very sorrowful.*

On another occasion, Ms. Williams returned to the hospital after a visit with friends. She said that she was homesick for her friends and did not want to come

back to the hospital. At this point, Ms. Williams could rarely identify or express her feelings. Since she alluded to an emotion (i.e. "homesick"), Dr. C decided to follow up.

Ms. W: *I felt like I was cooped up here in the hospital. Like there is nothing for me here. It's empty here. Everything for me is back home.*

Dr. C: *You mentioned feeling homesick. Tell me as much as you can about what it's like to feel homesick. If you were a poet, and put it in the words with the most feeling in them, what would you say?*

Ms. W: *I'd say that it's like a wound. It makes me suffer. Like I'm stranded and there's no one around. It's not an actual wound; it's worse than that. It's a wound to my feelings.*

Example: Mr. DeVito – applying words to body experiences

Here are two examples that involve Mr. DeVito:

1. *Roger DeVito began a session by discussing how he had sat by himself at work in the employees' lounge. Dr. B asked him to help him understand what it was like to be in his shoes, by painting a picture of his experience in words. Mr. DeVito began by describing a warm, unpleasant sensation in his chest, "heartburn" as he called it. As he and his therapist focused more and more on the details of these physical sensations, and as he became more and more precise about them, affect-laden words slowly began to emerge, and he was able to realize how irritated he felt at his boss. He said he often felt "hot under the collar", and said that he was afraid that his angry feelings might explode.*
2. *Mr. DeVito began a session by saying that he felt out of touch with Dr. B.*

Mr. D: *I feel hollow inside. Like there is nothing. Also, it is as if there is nothing coming in from the outside. It's as if there is a shield around me.*

Dr. B: *Describe the shield in as much detail as you can.*

Mr. D: *It's as if it's a beautiful spring day, and it's cool, but the sun is shining and making everything warm. But I can't get warm. Something blocks the sun.*

Dr. B: *You'd like to feel the warmth.*

Mr. D: *The warm feeling doesn't get through.*

Dr. B: *So, the shield mainly blocks sensations coming from outside you. It's not mainly a shield against what you feel inside.*

Mr. D: *Right. The sunshine doesn't touch me. You know I don't feel I have contact with anyone, maybe I have a kind of feeling against letting them in. Maybe it's a shield against people.*

Dr. B: *You would like to have some warm contact, like feeling the sunshine on your skin, but it also frightens you. You have told me how you feel so*

easily hurt by your friends and how much pain you have felt. Maybe this shield is to protect you against that kind of pain.

Mr. D: And also my aunt and uncle. They don't know how to comfort me. They're always rough and hard.

Dr. B: You'd like some contact with people to feel warmer, but you're afraid it will hurt you instead, and so you need a shield.

Mr. D: Right.

This last example illustrates several important ideas. First, one must take the notion of psychic determinism seriously enough to want to pursue Mr. DeVito's allusion to a shield. One must assume that Mr. DeVito's word choice at that moment was not capricious or meaningless—that possibly it functioned as a "switch" word (Freud, 1905) representing a link between several trains of unconscious thought. These are expressions that strike the listener's ear as being out of place, unique or singular in some way. Freud believed that they represent "nodal points" (Breuer and Freud, 1895: 290) at which two or more streams of unconscious thought converge. These points are often marked by notable or singular verbal usages.

One must assume that each additional image (e.g. sunshine, getting warm) carries specific meaning. For example, it may be significant that Mr. DeVito described the shield as being one against an external stimulus. This attention to the details of the patient's speech may seem pedantic and overdone and can sometimes feel tedious when put into practice. Nevertheless, it can bear a great deal of fruit, especially with patients who say they have no thoughts or feelings at all and who appear devoid of an internal life.

Enlargement

The technique of enlargement is linked to that of naming, and, in a sense, is an extension of it, but it assumes a broader lexicon of affective language. Once a patient has at least some capacity to attach words to subjective ideas and feelings, enlargement can be used to explore the patient's associations. I use the term *enlargement* to make a rough analogy to the process of magnifying photographs—the details of the image are expanded so that it can be seen more clearly. This technique, like clarification, involves asking the patient to "say more". Unlike free association, it focuses the patient on the task of verbal description in a more methodical way. If the patient feels like breaking off a description or association, sometimes (although not always) he is encouraged to pursue it anyway. If the patient has no more ideas on a subject, he may be asked nevertheless to continue to put his thoughts into words. This technique might be called "focused" or "directed" association. The purpose of enlargement is to reverse the process of breaking links (Bion, 1959) between important and related groups of ideas and feelings. The associations of psychotic patients are often broken down, or blocked; one idea does not evoke another. This breakdown of meaningful links is

more marked than in neurosis. Among these patients idea and emotion are barren and fruitless; they stop dead in their associative tracks. If a psychotic patient who begins by saying that his mind is empty or that he has "no thoughts" is encouraged to expand on the sensations and images he does have, sometimes a good deal of affect and fantasy will emerge.

Example: Ms. Thompson – describing fantasies in expanded detail

Ms. Thompson was a psychotic woman in her mid-twenties who generally was unable to verbalize her feelings, and left the impression that her inner life was quite impoverished and empty. On this day, she seemed filled with unspoken emotion.

Ms. T: *I wish I was far away with no worries. No hassles.*

Dr. D: *Tell me in as much detail as you can about what you wish. I'm very interested. Let's imagine that I was a magician and granted you all your wishes. What would they be? Take as much time as you like, and don't leave anything out.*

Ms. T: *Well, first I'd be the queen of a medieval kingdom, and I'd have a huge castle with a spiral staircase. I'd be the absolute authority, and I'd have lots of servants.*

Dr. D: *How many?*

Ms. T: *A hundred. No, two hundred. And everyone would curry favour with me. If I was displeased, I'd send them to the dungeon.*

Dr. D: *Your subjects, how would they feel about you? Would you want them to be afraid, or adore you for being kind or what?*

Ms. T: *I'd be the one who gave out the food. So everyone would obey me and respect me. If someone disobeyed, I'd send them to the dungeon without food, and where everything was silent. There would be no sounds, no music and the guards wouldn't be allowed to speak with them.*

Dr. D: *They would be alone, cut off from people?*

Ms. T: *Completely.*

Dr. D: *Cutting them off from people would make them suffer.*

Ms. T: *A lot. Then they'd lose all their feelings. They wouldn't be able to feel anything anymore.*

Dr. D: *So, let's go over what you've told me up to this point. As queen, you'd rule a kingdom and live in a huge castle. You would be in control, and if your subjects disobeyed, you'd punish them by sending them to a dungeon where there would be no sound, and no people. That would make them suffer. Finally, they'd lose their feelings.*

Ms. T: *Exactly.*

Dr. D: *If you were cut off like that from people, how would it make you feel?*

Ms. T: *It would be bleak. Like being insane. There would be no one and nothing. I couldn't stand it. I'd try to tune everything out.*

In the discussion that followed, Ms. Thompson began to talk about her own sense of isolation and her perception that her therapist was withholding and controlling. The therapist chose the subject of isolation and the deadening of feelings for expansion because these experiences were important and painful for the patient.

Enlargement is similar in some ways to Freud's early pressure technique in which he actively encouraged patients to associate to certain symptoms or events (Breuer and Freud, 1895: 270–280). The pressure technique with its emphasis on hypnosis gave way to a more open-ended form of association that Freud called "free association". For people with neurotic mental organization, whose cognitive links, conscious and unconscious, are reasonably intact, the main impediment to full conscious recall is resistance based on the repression of such links. In psychotic states, it seems that further violence has been done to associative bonds in the mental apparatus, resulting in blocking, thought stoppage and looseness of association. It appears that these interruptions in linkage are different in kind from those in neurosis. Unlike in neurosis, where the coherence of thought is intact but the awareness of it is blocked out, in people diagnosed with schizophrenia, disturbances in symbol use and cognitive linking disrupt the very functions and organization of thought itself. Whatever the mechanism, with psychotic patients a structured effort at creating associations and links can be helpful. This technique rests on recognizing emotionally charged words and phrases.

Example: Mr. DeVito – describing body sensations in expanded detail

Enlargement may be used to examine the meanings associated with body experiences.

Roger DeVito[1] had been feeling frustrated and painfully agitated.

Mr. D: *I have bad heartburn.*
Dr. B: *How do you mean? Do you feel that your heart is burning?*
Mr. D: *I mean that everything is moving inside. Like it's roasting. It's like nothing soothes me. I feel like my heart is roasting, that it's hot and I can't cool it down. I'm irritable with myself, with you and with everybody. So I stay away from people.*
Dr. B: *So that your anger doesn't get too hot?*
Mr. D: Yeah. I guess my anger is pretty intense sometimes.

Example: Ms. Weiss – describing word choice in expanded detail

Deborah Weiss said that her feelings had been "interred". This struck Dr. E as a curious way for her to express herself. When Dr. E asked her what "interred" meant, she had a hard time explaining. She said that it was just an expression. Dr. E asked her if she meant "interred" in the sense of dead, as one would inter

a body that was no longer alive. Or, did she mean "interred" in the sense that something might be located under a great deal of material, but that it still existed, and was perhaps still alive? Or was she using the word "interred" to refer to being trapped beneath a great obstacle that had to be removed for her to be free of it? As Ms. Weiss and Dr. E explored these various possibilities about what Ms. Weiss initially claimed was "just an expression", information emerged about how she felt cut off from people, how her feelings no longer seemed alive and how helpless and hopeless she felt about ever being "discovered" (or "disinterred") by anyone after so many years trapped in her emotional isolation. "Interred" actually turned out to be quite an apt term to summarize her experience.

Enlargement is a technique designed to help the patient express otherwise non-integrated thoughts and feelings. It is an extension of the usual technique of clarification used in psychoanalytic therapy. Obviously, it should not be used in such a way as to seem inquisitorial or persecutory (Olinick, 1954). Too frequent questions can sometimes make a patient feel put on the spot. This technique should be used tactfully in the context of a collaborative effort.

The use of enlargement or directed association will appear to be worth the labour of picking up associative threads with sometimes recalcitrant or distracted patients only if one takes the concept of psychic determinism seriously. All the words the patient uses, and each expression, must be taken as potentially vital signs on a treasure map, marking where to dig further. The example involving Ms. Bender's hallucination of the rasping sound given at the beginning of the chapter is, I think, a good one. The seeming disintegration of the patient's intentional speech should not deter us from being alert to nodal points. Patience and tenacity are very often rewarded.

Building the therapeutic relationship

The negative interpersonal reaction

As I mentioned at the outset of this chapter, whether the interpersonal relationship and the transference are different or the same is a matter of debate (Brenner, 1980). For this discussion, I will treat the interpersonal relationship and the transference as separate but related phenomena. The term *interpersonal relationship* will refer to vicissitudes of the actual interaction between patient and therapist, albeit coloured by transference and countertransference. One of the implications of discriminating between these two concepts is that some element in the therapist-patient dyad may be experienced as "new", "unique" or "real" to the patient, distinct from his past experience or transference expectations. This may, for example, include a correct perception about the therapist's emotional state.

In any event, the patient diagnosed with schizophrenia often responds to events in a concrete way. Even if a feeling or perception originates from a

transference reaction, it often must be dealt with as a real and concrete experience first. We hope that it can be connected to its past origins at some point. Thus, it is often unavoidable that the patient's emotional reactions are treated as if they are current interpersonal experiences. When they are examined, the distortions that emerge may lead to an exploration of what may be underlying the experience.

Perhaps the most important technical requirement in work with patients diagnosed with schizophrenia is to be in touch with changes in the interpersonal relationship. This relationship can be the first and final obstacle to the psychotherapy process, or it can be the tie, built up by human contact and shared effort, which can lift the work up into something that more and more approaches traditional verbal psychotherapy. The direction the treatment takes often depends on how the interpersonal relationship is monitored and what the therapist does at important moments.

For Freud, one of the sticking points in the psychotherapy of schizophrenia was that the patient could not observe a therapeutic "pact"; in today's language, a "therapeutic alliance" (1940: 173). The patient was too unpredictable and his powers of observation too erratic. His willingness to obey the rules of treatment based on his expectation of love from the analyst was too ephemeral. I do not agree that such a pact is impossible with psychotic patients. The alliance with the patient is central to therapeutic success.

As in therapeutic work with other patients, the alliance can be preserved and developed by looking at those things that interfere with its growth. Negative transferences, or, to be consistent, *negative interpersonal reactions*, should be identified, clarified and either interpreted, explained or both. If the patient feels intimidated, overly envious, contemptuous or ashamed, little work will get done. Attention to these negative interpersonal reactions is essential, and is the first order of business. The therapist should always be asking himself if the patient is feeling spiteful, envious, hopeless, humiliated or sadistic, and, if so, what he, the therapist, may have done or not done to prompt this response. The patient's willingness to put thoughts and feelings into words will depend on the state of his relationship with the therapist.

The importance of clarifying, confronting and interpreting the negative transference is also vital. As noted, however, given the often delusional concreteness of the patient, it may be extremely difficult to operate as if this were exclusively a transference matter. The patient's reality testing is not well enough established to appreciate that "everything is transference" (this often is not so easy for healthier patients). Therefore, it is often best to acknowledge what reality there may be behind the patient's reaction if there is one, and then explore what distortions may have been superimposed. If, after exploring both the patient's and the therapist's point of view about what "really happened", the patient can allow the possibility of a distortion, then an attempt to identify a transference reaction can be made.

Example: Ms. Williams – examining the patient's feeling of being misunderstood

Mary Williams was looking unhappy. She spoke as if defeated.

Ms. W: Sometimes, I feel like sessions make no sense.

Because of the way she emphasized the word "I", Dr. C thought that the patient might feel that she, Dr. C, saw things differently.

Dr. C: How do you think I feel about the sessions?
Ms. W: You seem so clear all the time. You say things that always seem clear and like they make perfect sense. You probably think things are going great. That's not what I feel. My thoughts are all jumbled. I don't know what I think or feel half the time.
Dr. C: So, when you're feeling jumbled and confused, I'm acting as if things are clear and simple. How does that make you feel towards me?
Ms. W: Like you don't know anything about what I'm feeling.
Dr. C: What you're saying makes sense to me. Actually, in the last few weeks I've often felt confused and nervous, like I don't know what's going to happen next. For some reason, I felt I shouldn't tell you about that. I don't know why.
Ms. W: That's the way I feel all the time.
Dr. C: I'm going to try to understand why I thought I shouldn't let myself feel those feelings or talk about them with you. I think this is something that would be good for us both to work on together.

In the example above, the therapist asked about the patient's perception of how the therapist regarded the treatment to see why the patient was so listless. She acknowledged the patient's view of her behaviour, and explored some of her own emotions and reactions, though not her personal past, unrelated to the treatment. In doing this, she used disclosure of what was probably an induced emotion, acted like a "contoured" or "defined" object, and explicitly emphasized the importance of working together with the patient. She thus modelled several attitudes and behaviours essential for collaborative work.

Here is another example of an effort to build the therapeutic relationship by means of self-disclosure.

Example: Ms. Williams – examining painful emotions in the relationship

As noted, Ms. Williams missed several sessions after Dr. C told her she would be graduating soon, and leaving the unit to work elsewhere in the hospital. When she did come, she reverted to the childish actions and provocative behaviour that

had first disrupted her work with Dr. C. Dr. C had expressed her anger to Ms. Williams about this. Ms. Williams had recently become more serious and able to discuss her sadness.

Dr. C: You know, it's painful to me sometimes when we meet. I often feel sad, and it's hard to feel some of these feelings. Somehow, I think, you're teaching me to feel some of the feelings you have. (The phenomenon of emotional induction had been discussed with the patient before.) Sometimes it's very painful. But, still, I think it's much better than before when you disrupted everything. Then, I couldn't think straight and I also didn't have a chance to know what I felt. Now, it's more serious. My feelings make more sense to me, and I get to know what you're feeling better too, I feel more connected to you.

Supporting the nonpsychotic part of the personality

Many writers have discussed the significance of the nonpsychotic part of the personality in working with patients diagnosed with schizophrenia (Federn, 1934; Katan, 1954; Bion, 1957). This is the only part of the patient that can form a stable partnership with the therapist in an effort to put feelings into words rather than actions. It is often helpful to refer to this partnership explicitly, to acknowledge the patient's achievements in ways small and large, in engaging in this alliance. This collaborative work is the only ground upon which any ego structure can stand, and its importance cannot be overstated. As Freud (1940) believed, if such a pact cannot be observed, no psychotherapy is possible.

Ms. Thompson complained that Dr. D used "ritzy words" and that she didn't understand her. Dr. D. appreciated this remark as an effort to make their relationship stronger. Dr. D also felt it was a risk for the patient to admit that she didn't understand her therapist's use of "ritzy words" because of her fear that she was not smart enough.

Ms. T: You use ritzy words. I feel ashamed and dumb because I don't know what you mean.
Dr. D: You're saying that I make you feel even worse about yourself.
Ms. T: Right.
Dr. D: It's very good that you said that. If you can, I'd like you to help me stop doing that, and talk more plainly.

On another occasion, Ms. Williams had been remarkably candid about feelings of loss and her need for other people. Dr. C felt it was important to acknowledge the steps the patient was taking.

Dr. C: You have shown me more of your feelings. You've taken chances by looking at your feelings, looking at things about me and talking with me

about them. I think that takes guts. You don't just blow up anymore. You stop, think, try to understand what you're feeling, and then decide what you're going to do.

Helen Jackson had been very intrusive and provocative during the early part of her treatment. In recent sessions, she had been much more thoughtful and open about her emotions.

Dr. S: I feel different with you today. I feel more calm. More relaxed and close to you. Like we have a relationship.

Ms. Jackson nods assent.

Dr. S: I feel this session is much different than a few months ago. I felt that with your barging in and being disruptive, that everything was coming at me at once, that I was being pushed back, that I couldn't think straight. I was anxious. Today, you are more thoughtful, you put your feelings into words. I feel I have room to think, to feel, and I feel closer to you. Also, I feel respect for you more. Not that I didn't respect you before, but I can feel it now. I feel like you are someone who has had pain, but who has integrity and value. It was hard to focus on that before with all the antics.

Matters of style

Prescribing a style for psychotherapy is impossible and undesirable. No doubt, the most helpful psychotherapy approach is a mixture of curiosity about the truth and respect and affection for the patient. Nevertheless, in work with psychotic patients, it may help to consider some stylistic approaches that differ from those commonly used with neurotic or borderline patients. These may expand the horizons of the therapeutic relationship. Of course, this is not to say that each technique is suitable to use with each patient. A playful manner may not be useful at the outset with a patient who complains of despair, inertia and mental confusion.

Bluntness

Sometimes, a patient may use the respectful, contained, even temper of the therapist in the service of resistance. He may say or do outrageous things to be provocative. Or, an artificially "professional" tone in the sessions may enable the patient to deny significant emotions. In such situations it can help if the therapist is blunt.

Ms. Reilley was a hospitalized adolescent who failed at several vocational programmes. She had just broken into the office of the occupational therapist and stolen some hospital files, thus risking discharge. She affected an air of

nonchalance and brushed off her therapist's effort to focus her on her behaviour and its consequences.

Dr. G: You try to be the joker and make everyone laugh while your life goes down the tubes. That's because your life has no value to you.
Ms. R: Huh?
Dr. G: You can't work at a job. And you've told me that no one respects you.
Ms. R: They do so.

Ms. R spits out her gum in the direction of the therapist.

Dr. G: I think you know that spitting at me is not a way for me to respect you more. You don't want to think about it, but you've told me that no one cares what you think and no one cares what you feel. You feel like a zero.
Ms. R: Everything is so screwed up! Everything sucks!

At this point, Ms. Reilley began a more genuine and thoughtful discussion of her feelings of despair.

Play

It may be useful with some patients to find creative ways of communicating and sharing experience. This may involve playing a game together or dispensing with the formality of the setting (for example, taking a walk with the patient, or switching chairs). Encouraging Ms. Thompson to pretend that her therapist was a magician who could grant her wishes is one example. Another is a role exchange in which the patient playacts the personality and stance of the therapist and vice versa.

Deborah Weiss had been continually complaining of lethargy, mental confusion and weakness. Several neurological workups were within normal limits, and her sense of torpor was variable and inconsistent over many years. Recently, her physical complaints had become a litany that seemed to kill creativity in sessions. Dr. E suggested that they reverse roles, and Dr. E then began to complain of his tiredness, his fuzzy thinking and so on. Each time the patient (now acting as Dr. E) tried to open a discussion of Dr. E's feelings or the meaning of his actions, Dr. E slammed the door shut by repeating his somatic complaints. Finally the patient and therapist discussed what this exercise had been like.

Ms. W: I understand now. You're making me see myself better. I'm pushing you away and shutting you down. It's like being constantly pushed away.
Dr. E: Can you see how this might get tiring and make me feel kept at arm's length, and feel like what's the point of working to understand things?
Ms. W: I certainly can.

Note

1 Mr. DeVito had an extensive neurological workup for unrelated reasons. This workup included a CAT scan and an EEG. The results were negative.

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5

TECHNIQUES IN SPECIFIC CLINICAL SITUATIONS

The therapeutic alliance and the degree of therapist activity

The importance of the interpersonal relationship and the therapeutic alliance was emphasized in Chapter 4. Sometimes, however, it is not clear whether making a particular intervention, no matter how reasonable, will strengthen the alliance or alienate the patient. On the one hand, patients diagnosed with schizophrenia are enormously sensitive to intrusion and what to them feels like coercion. If they feel invaded or violated, they will flee. Ms. Chen, for example, scrupulously guarded her "personal space". On the other hand, partly because of their use of denial, psychotic patients can travel far down the path of self-destruction with little concern, and can quickly bring themselves and their treatments to the brink of collapse. Although they may not acknowledge it consciously, they may leave it to the therapist to act adaptively and help avert disaster. Many circumstances are not clear-cut. The therapist is caught between the Scylla of overactivity and intrusiveness, and the Charybdis of being lulled by the patient's bland denial until suddenly the treatment is destroyed.

Negotiating these waters can be a demanding job. The therapist may feel that it is part of his psychological work to confront and interpret the patient's denial of danger, his use of splitting and his projection onto the therapist of his own capacity for self-care.

Example: Ms. Chen – should the therapist bypass denial to guard the patient's self-interest?

Ms. Chen, the teacher, provoked her school principal into firing her by not completing necessary school forms. She thus jeopardized her financial capacity to continue treatment. Nevertheless, she acted as if this was not a subject for discussion and that all somehow would be well. The therapist tried to interpret her use of denial, and pointed out that the treatment would be destroyed if she lost her job and could not pay. Ms. Chen felt that the therapist was intruding upon her "personal affairs" and declared that it was none of the therapist's business.

On the one hand, the therapist cannot simply collude with the patient's denial, while on the other hand, it is, in the end, the patient's life and he or she must be free to fail. Unfortunately, with psychotic patients, the stakes are often very high, and many failures are not easily reversible. Making sound judgments about when simply to listen, when to speak up and when finally to set limits on the patient's behaviour is a complex and difficult task.

Here is a second example:

Ms. Chen was suspicious and had numerous ideas of reference at her job. Her relationship with her family was becoming more filled with conflict, and this seemed to put pressure on her rather fragile sense of independence and identity. Frequently, she felt enraged that her autonomy was not respected. During this time, her therapist recommended a consultation with a psychopharmacologist and Ms. Chen reported that she had followed through. This turned out not to be so. Her therapist asked her about the consultation and Ms. Chen became incensed. She admitted that she had not made the appointment, then became evasive and finally accused the therapist of dishonesty. At work, sometime later, she called the assistant principal to her classroom to protect the school against the faculty's dishonesty. The assistant principal called her therapist from school. When Ms. Chen came for her next session she continued to feel that the troubles at work were part of her "personal space". She denied the emotional, social and financial danger she was in. Nevertheless, by giving the assistant principal her therapist's telephone number, she implicitly asked the therapist to act as an auxiliary ego.

Here is another example:

Example: Mr. DeVito – confronting denial

Despite his chronic psychosis, Mr. DeVito, who was in his mid-thirties, had worked for fifteen years as an accountant at a bank, had obtained at least two promotions and was apparently well respected at his job. Periodically, Mr. DeVito would become psychotic, and a variety of sexual and aggressive impulses, normally absent, would emerge. His psychoses were usually precipitated by a powerful conflict between a desire to become independent and develop a distinct identity, and a wish to become formless and helpless, and thus compel his uncle to intervene and take care of him. Many of his acute episodes were ushered in by concerns about his work, where he felt he was the victim of elaborate plots. He had relatively few friends. When he was not acutely psychotic, he felt that his work was a truly stabilizing force in his life from which he derived a lot of self-esteem. Work was a nidus around which what was clear and distinct in his identity could crystallize.

Mr. DeVito had becoming increasingly agitated and suspicious in recent weeks despite increased doses of medicine. His chronic delusions about being controlled by a "mafia gangster" were intensifying. He felt increasingly distrustful of his coworkers. He came to a session and announced new plans.

Mr. D: I'm going to leave my job. I think that's the best idea. I have no regrets. I'm going to tell them tomorrow. (Mr. DeVito had already taken several breaks from work, during which he stayed at home and was essentially taken care of by his uncle who lived nearby. Another absence might truly lead to the loss of his job.) Maybe at some point, I'll go back to the bank. But not now. I think maybe I'll open a small business of my own. Anyway, I'm glad I don't have the pressure of going back to the bank.

Mr. DeVito continued in the same vein, with emotional indifference to the consequences of what he was saying. Finally, his therapist spoke.

Dr. B: You want to kill off the adult in you, and act as if what you're going to do has no real consequence. I think among other things, you are showing how enraged you are at me and your uncle and aunt, but it comes out in your destroying yourself. But you seem to have no concern about this, as if it doesn't matter. As if your concern for yourself and your wish to become an adult are locked up in some compartment that doesn't touch you. You say all this in such an offhand way. As if destroying your adult life is nothing. If you lose your job, you will have no income, and your uncle will feel pressured to come in and take care of you. And you will lose your chance to separate from him and become an adult. Your goal of growing up and having a relationship with a woman seems to have vanished.

Mr. De Vito continued to maintain that his actions were no big deal.

Dr. B: I think your fears about the gangster stand for your terror at moving away from your uncle and aunt, which you've never done. I think you're furious at them and at me about having to become separate. It's easier to be taken care of at home. It's as if you want a life of leisure with no demands or pressure or risks. Since you're not rich, one way to do that is to act like you are crippled and frighten your uncle into taking care of you. But in doing this, your identity as an adult is crumbling. Each day you become more and more like a featureless lump. If you have no self, what value would your treatment have with me? What goal would we have? What would we work on? You're asking me to be your doctor and to give you my honest point of view, not to watch silently or reassure you while you destroy yourself.

To be sure, this was an uncharacteristically lengthy statement by Dr. B, but his intention was to interpret Mr. DeVito's denial of external social reality, and his use of splitting, which enabled him to remain unconcerned about what had once been important wishes for self-sufficiency. Dr. B wanted to address Mr. DeVito's wish to give up his distinct identity and merge with the lives of his family. One

might argue that Dr. B departed from technical neutrality by urging Mr. DeVito to take a course of action. From another point of view, Dr. B was urging him not to act precipitously in response to internal pressure to flee his job. The therapist's goal was not to direct Mr. DeVito's career choice, but to address the psychological processes that had gathered steam and were threatening to damage his functioning.

After several sessions such as the one above, Mr. DeVito, with increased medication, was able to settle down and return to his job.

Clarification, confrontation and interpretation of splitting, projective identification, denial and wishes for merger do not always succeed. The pressure of the patient's inner needs and the impairment of his ego functioning sometimes interfere with his ability to step back, delay and use concepts to examine what he is doing. In fact, interpretation of primitive defences can make the patient more evasive and paranoid. These responses alert us to the diagnosis of structural psychosis (see Chapter 2).

In situations that threaten the patient's physical, social or financial well-being, and thus the viability of the treatment, the therapist has no choice but to interpret the use of primitive defences, even though this may stir up enmity and suspicion in the patient. Certainly, there are less dangerous circumstances in which one can afford to be less therapeutically insistent. To some degree, one's level of activity and persistence can be guided by the patient's subjective capacity to tolerate one's interventions. With sicker patients, one may be tempted to ferret out latent negative transference and primitive defence—to make preemptive strikes, so to speak—so that these processes do not work silently to undermine the treatment (Reich, 1945; Glover, 1955;[1] Kernberg, 1975, 1984). However, such interventions sometimes do intrude upon the patient's freedom to conduct their psychological work in their own way.

Example: Mr. Tilden – the question of therapist activity versus patient autonomy

Mr. Tilden often jumped from topic to topic during sessions, as if throwing emotional issues overboard, never to be heard of again. There appeared to be few unifying themes. His therapist believed that he used splitting and denial to keep these various aspects of himself disintegrated. She also felt that her confusion must in some way mirror his own. She pointed out that his accounts of himself were usually disjointed, and that he rarely stuck with one topic. This had happened before, and she had not hesitated to interpret his use of splitting, denial and projection. Now, Mr. Tilden responded in a poignant way. He said, simply, that he knew that. He added, "I need to find something to talk about in my own way, when I'm ready." Mr. Tilden and his therapist debated this a bit, but in the end, the therapist thought that maybe Mr. Tilden was right. She relaxed her vigilance concerning his use of primitive defences and the negative transferences and, in fact, over the following months, Mr. Tilden did extremely productive work, albeit in a somewhat roundabout way.

On another occasion, Mr. Tilden complained about the therapist's confrontations of his overt and covert aggression.

Mr. T: The way you talk to me makes me feel awful about myself, like I'm a bad, evil person. You say that I hate people. Well, maybe I do. Maybe I do. But I can't take your pushing it in my face all the time. It's too much. I feel like I can't escape it. What do you want me to say? It's true? Okay, it's true. Maybe I'm supposed to be able to handle this being pushed in my face, but I can't. Okay, it's true, I do hate people, but I can't take it being pushed in my face all the time.

A similar example involved Ms. Chen:

Ms Chen chided her therapist for what she felt was his excessive activity and concern for the consequences of her behaviour. She said, "I don't need a boss to tell me what to do or how to do it. I need someone who will be there to hear me out." She asked in a very ingenuous way if maybe she and the therapist could slow down and let Ms. Chen take more initiative.

Boundary issues in the treatment setting

People diagnosed with schizophrenia often have problems with their sense of boundary. These were touched on briefly in Chapter 4 and alluded to at the beginning of this chapter. They will be discussed further in Chapter 6. A number of primitive defences appear to contribute to the problem. Rapid cycles of primitive projection and introjection can undermine the distinction between what is self and what is other (Kernberg, 1975, 1984). Defensive fusion of self and object images designed to effect a primal connection (Jacobson, 1964) certainly works against clear definition of boundaries. The boundary between self and other may never have fully matured in the course of development (Schafer, 1968; Loewald, 1980). The de-conceptualization of experience and the re-perceptualizing or re-sensationalizing of thought make it difficult to discriminate between sensation, perception, thought, feeling, memory and fantasy, and thus also contribute to the uncertainty about what is inside and what is outside. Scotomatization and denial of perceptions of reality (Freud, 1927: 153, n. 2; Jacobson, 1957) undermine the person's relationship with the external world, and thus contribute to its being confused with the internal.

It is important to keep in mind that the boundary disturbance has an affective as well as a cognitive component. People diagnosed with schizophrenia often feel that there is no barrier between the behaviour of another person and their own emotional responses. If another person is angry, they tremble with fear. If another person commands, they feel compelled to obey. There are few inner resources to rely upon for emotional anchorage. It is difficult for the psychotic individual to fend off or insulate himself from external affective influences. He feels like a slave to his emotional environment and feels humiliated, impotent and angry

about his capacity to erect an effective barrier to affect. It is unclear whether this emotional porosity is due to a need for a primitive affective unity, a fear of the separateness implied by greater emotional "immunity" from external influence, a deficit in a neurophysiological stimulus barrier or other factors. Whatever its origins, this porosity probably contributes synergistically to the disturbance in the cognitive margin between inside and outside, and self and other.

The patient's difficulty in discriminating inside from outside, and self from other, can manifest itself very early in treatment. It may make it hard for patient and therapist to engage in a dialogue, or even to occupy the same room. The patient may feel that the therapist is overwhelming him, coercing him or insisting that he submit to the therapist's control. In part because of primitive wishes for fusion, the patient may experience the therapist as intolerably close, so that his sense of separateness is threatened. He may feel that the therapist leaves him no room for a distinct existence, that his heart and soul are being taken over. Or, he may feel that the therapist is interested in him only as an extension of himself, and is not really interested in what the patient actually thinks or feels.

In response to these fears, the patient may try to break off the relationship to ensure the survival of his own distinct identity. Or, he may try to control the therapist's actions or speech to protect himself from intimidation or annihilation. For his part, the therapist may come to feel that he cannot say or do anything, much less anything confrontational or controversial, without the patient becoming enraged or storming out. Thus, the therapist may be tempted to retreat to the position of an observer rather than a participant. Ironically, he may then begin to feel that the patient has come to control *him*, and that his own identity as a therapist is slipping away. There is no simple solution to this therapeutic predicament. Since from the very outset, the patient may experience conflicts about boundaries, there may be precious little in the way of alliance and goodwill to ease the tensions that develop. One must rely on some combination of countertransference insight, emotional disclosure, tact, humour, inspiration and patience to find one's way.

A rather long example will, I hope, illustrate this point:

Example: Steven Tilden – can both patient and therapist be a self?

Steven Tilden had just begun his therapy. He came from a family in which he felt that his mother patronized him and was not really interested in what he had to say. He described his father as an extremely conservative and strict man who had to have things his own way. He felt that within the family, his identity had been crushed, and believed that much of his rage stemmed from feeling "squelched".

For several weeks Mr. Tilden seemed very comfortable in sessions and alluded to having a crush on his therapist, but he managed to avoid discussing this in any detail. He missed a few sessions, and then began to talk about his romantic feelings again at the very end of another meeting. He complained that the therapist stopped the session (which she did on time) because she didn't want to hear what

he had to say. He was now so angry, he didn't want to talk about the subject anymore.

During the next session, in which he continued to berate his therapist, Dr. T commented that maybe Mr. Tilden wanted to fight with her to avoid feeling affection. He promptly became furious and unleashed a stream of invective, complaining that the therapist did not listen and did not care about him. She thought only about herself, and always wanted to bring the focus back to herself. The sessions always focused on what the therapist wanted to discuss, and it was obvious that she didn't give a damn about him. She just wanted to make money and feel like a big shot. He hated her and didn't want to tell her anything. This was all said with great conviction, and a deep feeling of offence.

At this point, the therapist felt roundly criticized. She felt like a little girl who had been scolded, as if she had been bad. She felt sad and guilty. As the session went on, the therapist felt stifled, pent up, inhibited from talking and demoralized, as if what she had to offer wasn't wanted or needed. She worried that if she didn't say something soon, she would forget what useful ideas she had to offer, and that her sense of therapeutic purpose was evaporating. She felt as if she was simply occupying space in the room.

The therapist encouraged Mr. Tilden to say more, but he was not interested. Finally, not quite knowing what else to do, she shared her personal reactions (detailed just above) with him. He eyed her with dismay.

Mr. T: You're blaming me again. Everything I do, you find something about it to criticize. You make me feel like I'm a bad person. I never get a break, a chance to say what I have to say. You always want to do all the talking, I come here to get things off my chest, but you seem to have more of a need to speak than I do. (His face shows great pain.) This is just the same thing that happened at home. I shouldn't have to keep quiet because you have a need to speak.

At this point, the therapist explained her rationale for disclosing her own feelings to Mr. Tilden. This had been done several times before.

Dr. T: I wasn't trying to criticize you. I told you what I felt because I've found that sometimes the way I'm feeling says something about what you may feel. Like when it's hard for you to keep your thoughts clear. Maybe you feel squelched in some way, then kind of hopeless, and then useless as I did today.

Mr. T: Well, I didn't get that from what you said.

Dr. T: Obviously not.

Mr. Tilden smiled and visibly relaxed.

Mr. T: But you should pay attention to what I was saying. When you're speaking all the time, I don't get a chance to say what I *have to do. Really,*

I'm not trying to rebel or give you a hard time. But I have to feel like you're listening to me and that you feel what I'm talking about is important. Otherwise, I'll never want to tell you what I'm really feeling inside.

Dr. T: I've thought about this a lot. And when I look within myself I think I was talking in order to say something you should hear. But whether what I said to you was useful or not, I want you to know that I am listening to you about your need to have a chance to say what's on your mind.

Mr. T: What are you feeling now?

Dr. T: More comfortable. More relaxed. And you?

Mr. T: Me too.

It occurred to Dr. T later that Mr. Tilden may have had a need for her to feel squelched and useless not only to communicate to her what this experience was like for him, but also to see if she could tolerate these feelings without becoming demoralized or disorganized as he often did.

Examples: Mr. Stevens and Ms. Chen – can two selves coexist?

Mr. Stevens had been talking for about twenty minutes when the therapist made his first comment. Mr. Stevens complained that he was not being given room to talk. The therapist commented that it was as if the "town" were not big enough for the two of them. Either he, the therapist, existed, and Mr. Stevens felt crowded out and annihilated, or Mr. Stevens existed, and the therapist seemed to vanish. It appeared difficult for both of them to exist in their own right, with their separate identities, without one of them feeling erased. Mr. Stevens agreed.

Ms. Chen experienced powerful rages at the people she was closest to, and when under stress, she responded with suspiciousness and ideas of reference. Her mother had been exceedingly intrusive and destructive of her daughter's autonomy. Ms. Chen had missed one recent session, and now asked if she and the therapist could reduce the frequency of their sessions. Among other things, the therapist asked Ms. Chen about her feelings toward him. Ms Chen seemed upset and said that she did not want to talk about the relationship. The therapist asked her why not. Ms. Chen answered that the more they talked about their relationship, the more she would be burdened, and the more she would have to worry about the therapist. Whenever the therapist asked her about her personal feelings toward her, Ms. Chen felt as if a dentist were probing at her skull rather than her mouth with an instrument.

Ms. Chen's fears illustrate how fragile was her grasp of her own separateness. Her worries also demonstrate the intimate connection between boundary disturbances and disturbances of identity. She continually tried to shore up the boundary between herself and her therapist because she feared that otherwise, her life and the therapist's would begin to run together like watercolours. She would feel prodded and poked like a research specimen. She also feared that the therapist would change the shape of her body. Ms. Chen had used the image of her body shape before, and it seemed to be a metaphor for her sense of identity. If she and her therapist got too

close, the therapist would have undue influence over her, she felt, and could alter her according to her will. Ms. Chen's fear of influence seems to be a good example of the *affective* boundary disturbance mentioned at the outset of this chapter.

The experience of emptiness and deadness and its impact on the therapist's ability to listen

Often, if not invariably, people diagnosed with schizophrenia feel empty and dead. We can understand this in several ways. Frightening emotions may produce such pain or fear that people try to protect themselves against affects of any kind (Eissler, 1953; Will, 1975; Searles, 1979: 16).

Some patients seem to distinguish between emptiness and deadness. Phenomenologically, emptiness seems to refer to a state of "missing" something of which they are only dimly aware. It is very painful and exerts a persistent pressure. People who describe this kind of emptiness are motivated to remove this state with some form of input, satisfaction or distraction. In contrast, people who feel dead inside seem not so much anguished as apathetic. They are not so much searching for something that will pleasantly fill them up, or relieve an inner gnawing, as they are mechanically going through the motions without desire. They are indifferent to everything.

Both the experience of emptiness and deadness can play a central role in the emotional lives of people with psychosis

Here are some examples of what patients report:

Mr. DeVito referred to his emotional life as a "desolate valley where no one ever sets foot". If someone did appear, he would feel unnatural and grotesque next to a person who was "real". His inner life, he said, felt like a grey dungeon.

Ms. Weiss said, "I am barren. There is nothing inside to give to anyone."

Ms. Chen disclosed, "I feel like a forest after a fire, with no trees. It needs people to care for it, to fertilize, plow and plant trees so there can be some life." Later, she added, "Sometimes in my imagination, I see a photograph of my body which is crumpled and torn into bits."

Ms. Williams, a tough, pragmatic young woman, not given to lyrical abstractions, self-disclosure or hyperbole, said, "At times it's like I am a huge expanse of nothing. I don't feel human when I'm all alone."

A number of patients referred to a sense of deadness. Both Mr. DeVito and Ms. Weiss referred to themselves as "dead heads". Ms. Weiss commented that her emotions were "dead and buried". Mr. Sands, another patient diagnosed with schizophrenia, reported, "Nothing seems like it's worth doing. Everything just seems empty. I have nothing to talk about."

The origin of these patients' feelings of emptiness and deadness is unclear. Psychologically, people may defend themselves against tormenting affects by shutting down their emotional reactivity. Ms. Williams stated, "The feeling of missing people is torture, not physical torture, but mental torture." Mr. DeVito, who complained that his feeling of emptiness was like having "pieces of iron"

in his stomach, said, "I'd rather have iron than feel desperate and alone." These defences may lead to a shutdown of feeling or desire or both, and thus progressively to emptiness and then deadness.

Or, the sense of emptiness may express a painful, inescapable, gnawing hunger for soothing, relief and spirit-quickening contact. The feeling may express a structuralized and chronic emotional position, or a more transient contemporary experience.

Often, there is no active intervention that will directly relieve these people of the pain, hopelessness, futility or nihilism that arise from feeling empty or dead. Straightforward encouragement may be temporarily soothing, but frequently it does little to change the person's chronic inner experience.

Despite the fact that these feelings present an enormous therapeutic challenge, I include a description of emptiness and deadness in this chapter on technique because it does require a specific and very difficult technical response: listening. To listen to the patient talk about his inner hollowness, his feeling of being inhuman, his humiliating envy of the therapist for having all the patient himself wishes to have, is hard to tolerate. In this sense, these patients are not emotionally impoverished. If one marks the depth of the patient's emotional life by the depth of poignant pain it can induce in the therapist, then these patients' emotions run frighteningly deep. It is not easy to sit with someone, encourage him to take off his emotional shirt and then stare at his gaping affective wounds. No doubt this is part of why the practice of doing psychotherapy with patients diagnosed with schizophrenia has not inspired more enthusiasm. Approaching such patients from a pharmacological, biological or cognitive perspective, as valid and useful as these avenues are, may spare the clinician from some of the deepest reaches of countertransference pain.

To help the patient with feelings of emptiness and deadness, the clinician must be willing to tolerate the stirring up of similar feelings in himself via emotional induction. He must also be willing to feel his own versions of emptiness, nihilism, deadness, hopelessness and envy. The patient *may* feel less isolated, excommunicated and alien if he feels that the therapist is comprehending his inner experience, and that there is common ground between him and the clinician (Sullivan, 1953).[2] The patient will certainly *not* feel differently if the therapist cannot receive these disturbing and intense feelings into his heart. I am not saying that the therapist should suffer in the same way the patient does. Even if it were possible, that would lead to dysfunction and is based on a false premise of symbiotic cure. But to avoid emotions that are induced by the patient is to lose an essential compass in guiding the therapeutic work. It is also, perhaps, to lose an opportunity to send a crucial signal to the patient that the therapist cares enough to stand by him in his pain.

Pressured speech and looseness of association

In many of the examples I have cited so far, the patients have spoken relatively coherently, even if angrily, contemptuously or irrationally. Of course, this does

not always happen, and many people diagnosed with schizophrenia demonstrate looseness of association, tangentiality and circumstantiality. Since verbal psychotherapy depends on the patient telling a reasonably coherent story, what does one do?

In my experience, it has been helpful to apply the techniques of naming and enlargement to the patient's bizarre productions. Often, the therapist must first explain to the patient why he, the therapist, is interrupting: that the therapist is taking the patient's use of words *very* seriously, that the patient is going too quickly or jumping too fast for the therapist to follow. The patient is encouraged to slow down, take one idea at a time and explain in great detail precisely what he means.

Some patients are able rather quickly to make use of this advice. They are able, in fact, to slow down, and although further clarification is necessary, their story becomes much more comprehensible.

Other patients do not benefit so quickly. In these cases, it is worthwhile to enquire whether the patient understands why the therapist is saying that his remarks are hard to follow. The patient's idiosyncratic speech may reflect a psychotic incapacity to empathize with the social criteria of reality (Kernberg, 1975, 1984). The patient may not understand how another person reacts to this behaviour. If this is so, it may be helpful to underscore how difficult it is to follow him, and to suggest that he speak more slowly, more clearly and with fewer sudden leaps of content.

Or, the patient may be motivated to be incoherent. Recall Ms. Williams who said that she spoke incoherently at activities therapy because she did not want others to know what she was feeling. Words are powerful tools that can help send messages about inner states from one subjectivity to another, but they also can be used to mislead, deceive, evade, hide and obscure. One may need to examine with the patient whether he wants or does not want the therapist to understand him. If he does not, it is important to know more about why not. It may be useful to make a joint agreement about which subjects the patient feels comfortable discussing, and which, for now at least, he does not.

Example: Ms. Jackson – pressured speech

Ms. Jackson, a woman in her late twenties, began her session by talking rapidly. She jumped from one subject to another. In the course of about five minutes, she talked about how she missed her boyfriend, then about how they attended a party, then about how it was when she was living with her aunt, then about her sister's work as a teacher. The transitions were abrupt, and while her therapist assumed these subjects were connected, and could make up connections to fit, the rush of topics seemed like a jumble.

Dr. S: *I am sorry to stop you, but you started by talking about your boyfriend, and ended up talking about your sister being a teacher. How did you make that jump?*

Ms. Jackson repeated a similarly pressured, obscure sequence.

Dr. S: *Again, I'm sorry to stop you, but you're talking about one thing and then go on to several others. Can you see that it would be hard for me to follow you along?*
Ms. J: *Yes. I do know what you mean. I think I want to talk about my boyfriend.*

Ms. Jackson proceeded to talk about her boyfriend in a way that the therapist could follow.

Example: Ms. Hunt – looseness of association

Dorothy Hunt was a young woman who had florid psychotic symptoms for many years. She was grossly delusional, had paranoid ideas, ideas of reference, auditory hallucinations and inappropriate affect. She had no friends.

Ms. H: *I want to be a farmer and I want to live in a commune because the air in the day hospital is so bad, I can't breathe it. And everyone knows you can't be healthy if the air is no good. The air you breathe makes you what you are. Don't you think?*
Dr. U: *From what I can tell farming and good air are very important to you.*
Ms. H: *Well, yes. Anyway, that's what the spirits are making me feel. They influence me from the stove.*
Dr. U: *You're telling me that spirits influence you from the stove?*
Ms. H: *Uh huh. But I never really made any friends when I lived with my grandfather.*
Dr. U: *I'm going to interrupt you. It's not because I'm not interested in what you're saying, but because I take each of your words very seriously. I want to make sure I understand each of them.*
Ms. H: *My aunt wants me to call her every day and . . .*
Dr. U: *You know, I'm sure what you're saying is important. And I want to ask you more about it in a little while. But, first, I want to make sure I understand what you were saying about the spirits. That seems important to you since you've brought it up several times today. Do they live there? Are they there all the time? How did they get there? How do they know about you, and why do you think they are interested in you? (The day before, the patient and therapist had begun to discuss the spirits.)*
Ms. H: *You know, I was watching TV, and an old episode of "Dragnet" came on and . . .*
Dr. U: *Can you see how I might think that you are changing the subject?*
Ms. H: *I guess I did.*

The doctor and patient were finally able to discuss the spirits in a less haphazard, more comprehensible way.

The same patient, several months later, had just come from an interview at a day programme.

Dr. U: *How did it go?*

Ms. H: *They are all talking about me. Like they know something about me. There was something in the air, like drugs. Or maybe some kind of poison. You know, I like to take a shower at least twice a day. To have a fresh smell. I wonder if my grandfather remembers that I stole money from him.*

Dr. U: *You know, I'm not sure I understand. You've talked about so many subjects, it's hard for me to keep them straight. When I stop you it's so that I can really try to understand each of the ideas you're telling me about, each of the words you use. Otherwise it would be like you're talking to the wall. Maybe you don't really want me to understand you, like when someone uses a secret code. But if you do want me to know what you're saying, you need to slow down. And I'll probably need to stop you and ask more questions.*

Ms. H: *I see your point.*

Example: Ms. Bender – looseness of association

Here is another example which is also an example of working with feelings of loss and emptiness:

Ms. Bender was a 45-year-old woman who was grossly dishevelled, had chronic auditory hallucinations and somatic delusions, and lived in a supervised residence. She had not worked in years, and had no friends. She had in the past lived with a roommate in a supervised residence. This relationship developed into perhaps the deepest friendship she had ever experienced. She began the session in the following way:

Ms. B: *My friendship was like a chocolate cake.*

Dr. M: *How do you mean?*

There was a long pause.

Dr. M: *I think that comparing your friendship to a cake probably has a lot of meaning. I want to try as best I can to understand what you're trying to say. How was it that your friendship was like a chocolate cake?*

Ms. B: *When I came back to the apartment, Sandra and I would listen to music together. (Pause) The feeling was good.*

Dr. M: *So, looking back on the times you were with Sandra, listening to music, there was a particularly good feeling.*

Silence.

Dr. M: *And the picture of the chocolate cake? If I think of chocolate cake, I get a picture of something sweet, special and delightful.*

Ms. B: *Our friendship was barren and cosy.*

Dr. M: *Can you tell me some more about the barren part?*

Ms. Bender looked pained and sad. After a long time, she spoke.

Ms. B: *Dr. M, certain things are impediments. I think I've lost my breath for today.*

Dr. M: *If you don't want to go on with a subject, please let me know. We don't have to continue with this right now if you're not ready to talk about it. Just let me know if you don't want to talk about something, and we'll wait for a time that you feel more able to. All you have to say is: "I don't want to talk about that right now." I don't want to talk about anything which is uncomfortable for you when you're not ready or don't want to.*

The approach to pressured speech and looseness of association that I have described addresses the relationship between the speaker and the listener. It assumes that even if the patient is communicating idiosyncratically, there remains a nonpsychotic part of his personality. This nonpsychotic part is capable of understanding that he is either not making the effort to translate his inner experience into conventional and public symbols (words), or is failing in that effort. This approach addresses the *process* of communication, rather than the content per se, so that a more reliable form of exchange can occur, and the clinician is not left, session after session, to perform miracles of comprehension.

There is another approach, which may be useful from time to time, and that is to treat the patient's words as word conglomerates, not sentences. Freud (1900) described how the manifest dream text was actually a conglomerate, a patchwork of symbols and signs that had no *conceptual* relation to one another (except that added by secondary revision). The elements were related not by *conceptual* or *logical* association, but by associations based on contiguity in time, place, sound and so on. The speech of people diagnosed with schizophrenia, similarly, consists of conglomerates of ideas, symbols and associations, and as the person talks, a kind of background music may emerge. Ideas and affects related to certain themes may appear.

The theme of Ms. Bender's cake metaphor was intimacy and loss. Ms. Bender and Dr. M had many more conversations that were much more opaque than the one described above, and that would be much too long to quote in full. They required many slowings-down, much naming and enlargement, and very often yielded themes related to sadness, loss and loneliness. As mentioned above, however, even when she and Dr. M were able to understand the meanings behind her statements, the method of communicating and translating remained problematic.

Hallucinations

The approach to the patient who has hallucinations is not markedly different from the patient who has looseness of associations. It is important to address the use to which hallucination is put, as well as the content. People often use hallucinations as alternatives to conceptual forms of communication, both to others and themselves. Searles wrote, "In general, and to a high degree, psychotic patients experience inner emotions not as such, but rather as distorted perceptions of the outside world" (1979: 13). In other words, the person defends himself from too poignant, too frightening or too painful emotions by taking them out of the realm of the "inner life" and out of a form (concepts) that convey their meanings and connection to other meanings. Such richness and echoing of meaning is simply too painful or overwhelming. Emotions are deflated, deconceptualized, desymbolized, and finally sensualized and perceptualized. The person does not feel sad, but has the sensation that his heart is heavy and literally sinking in his chest (e.g. Mr. DeVito). The person does not feel angry at his boss, but rather experiences heat in his chest (e.g. Mr. DeVito). The patient does not feel pressured by his therapist, but has the sensation of a dental instrument pushing on her skull (e.g. Ms. Chen).

To understand what lies behind the hallucination psychologically, one must explore it using naming and enlargement. The goal is to return the emotional and conceptual associations that have been squeezed out of the patient's inner life. In illness, surplus emotional meaning infuses the person's physical sensations, making them bizarre and uncanny (Bion, 1956). If the therapist explores these sensations with the patient, and asks him all that comes to his mind about them, exactly what they feel like, where they occur and what thoughts or feelings accompany them, feelings and meanings may begin to seep into the patient's account.

Example: Ms. Bender – hallucinations

Ms. Bender came for her session, and Dr. M asked her what had led to her hospitalization. She evaded the question and went on to discuss other things in a desultory way. Dr. M led her back to the topic of her hospitalization, and she then reported seeing an object that looked like a scouring pad near Dr. M's chair. Dr. M asked her what this looked like and what it made her think of. She described the appearance as rough and abrasive. Finally, she said, "Like the appearance of someone who is irritating and pushy." The patient and therapist then talked about her dislike of Dr. M's persistent questioning about her family.

Delusions

Obviously, delusions are complex phenomena. They may be connected to perceptual distortions such as hallucinations. One may hear *sounds* or voices coming from the refrigerator; that is a hallucination. To develop the related *belief* that this

means that people live in the refrigerator is a delusion. A delusion is a belief, not consensually validated, that is maintained with a certainty. If the person is not certain about his belief, if he entertains some doubt, we may call this an overvalued idea, and conclude that his reality testing remains intact.

Psychologically, delusions come about because of the interaction of the person's wishes with his perceptions and concepts about what is real. Strengthening or weakening of either element can alter the balance of forces and result in either more realistic or less realistic beliefs. If the person uses the defence of denial and blocks out the awareness of large portions of external reality, then conviction about his fantasied version of that reality is given freer license. If the individual's wishful needs to maintain a particular belief grow powerful, then even if the functioning of his ego is usually intact, his need may overwhelm his powers of observation. If, for example, one is captured and held hostage, one may defensively come to believe in the righteousness of one's captor's cause.

Delusion formation may be seen as closely related to the process of forming and telling lies. We develop a lie, an altered version of reality, for the consumption of those around us, because it serves our interests. Often, these lies serve our emotional needs. While a lie may at first be the product of a conscious, intentional act, over the passage of time the circumstances of its origins may fade in memory, and the emotional comfort it gives may be so compelling that it acquires an affective *feeling* of reality. It may sometimes be a rather short step to develop a *cognitive* conviction as well.

Superego functioning no doubt plays an important role in this process. Hartmann (1953: 200–203) has discussed the role of superego functioning in the testing of reality. One's "moral" allegiance to truth telling (and thinking for that matter) that develops in the context of object relations within the family may affect one's willingness or unwillingness to "modify" truths for defensive purposes.

In any case, with patients who present delusions, it is valuable to determine whether they unequivocally believe in the distortion they report. When confronted with contradictions in their stories, or with the illogic or lack of consensual validation of what they assert, patients may acknowledge that, perhaps, their belief is not so. In this case, the patient is not psychotic, at least so far as this particular belief is concerned. He may, in fact, simply be distorting the truth. He may be presenting what appears to be a delusional belief, ultimately knowing it to be untrue, for ulterior and perhaps manipulative reasons.

To complicate this further, we may theoretically believe that there is always a nonpsychotic part of the person's personality. If this is so, then there remains some part of the psychotic patient's mind that is aware his delusional belief is false. The difference between delusion and conscious distortion then hangs on how integrated or conscious this "nonpsychotic" portion is, or is not. Evaluating this can be tricky indeed.

In any event, the approach to the patient with delusions is complicated. Mostly, it serves no purpose to confront the patient with "the truth". The patient has developed his distortion over time for powerful reasons, not easily swept

away by common sense. Two procedures are useful. First, it is important to understand the emotions that are connected to the delusion. We then may be able to grasp the context in which the delusional belief occurs, and what function it serves in the patient's psychic economy. Second, the clinician can tactfully enquire about how the patient understands the relation between this (delusional) belief and other beliefs of his that seem to contradict it. This is *not* done to coerce the patient's agreement with convention, but to map out the boundaries of the distortion and, if possible, help the patient become aware of his own potential for doubt.

Example: Mr. DeVito – delusions

Mr. DeVito had once again come to fear being taken over by the "gangster". He believed that the head of an organized crime family somehow lived in his heart. The gangster would eventually take over his mind, leading to terrible consequences. Eventually, everyone would be destroyed.

Increasingly, Mr. DeVito felt the influence of the gangster in his heart and was becoming suspicious of his colleagues at the bank.

Mr. D: *The gangster is getting stronger.*
Dr. B: *How do you know?*
Mr. D: *Two clerks at the bank told me so.*
Dr. B: *Why would you believe them?*
Mr. D: *When I have confidence in someone, I tend to believe them.*
Dr. B: *But if I told you that you were Abraham Lincoln, you'd think something was fishy.*
Mr. D: *(Laughing) That's true.*
Dr. B: *Well, I guess what I don't understand is why you'd put stock in what these two clerks have to say. You hardly even know them, much less have reason to trust them.*
Mr. D: *I'm not sure.*

After some more discussion, Mr. DeVito continued.

Mr. D: *I'm ready to stand up to the gangster now. I know if you're honest and good, it gives you strength.*
Dr. B: *So being honest and good gives you strength to stand up to the gangster. What has made you believe more in your honesty and goodness?*
Mr. D: *Before I believed all the rumours and lies about me.*
Dr. B: *Are you saying that when other people don't believe in you, it weakens your own faith in yourself?*
Mr. D: *Definitely.*
Dr. B: *Can you give me an example of how other people's lack of faith weakened you?*

Mr. D: Yes, my uncle sometimes tells me I'm sick, and that I shouldn't try to do too much for myself. When he says things like that I feel why bother trying. What's the point?

Dr. B: Why do you think you let your uncle's ideas influence you so much?

Mr. D: I don't know. It's important to me that he likes me.

Dr. B: What you're saying is that because you want him to approve of you, you're willing to change your opinion about yourself.

Mr. D: Yes.

Mr. DeVito went on to talk about how he first came to believe that a gangster lived in his heart. He said he was in an Italian restaurant when he heard a voice, like when you hear your own thoughts. Dr. B asked if the voice was inside or outside his head. Outside, it said. He then thought he heard a waiter and waitress talking about how organized crime would take over everything. These thoughts are not mine, he thought.

Dr. B. took a moment to explain the reason for his questions.

Dr. B: I want to be clear. I am not trying to influence your beliefs about the gangster. I want to know more about how your ideas and feelings connect with each other, and how your beliefs about the gangster have become so strong.

Later on in the treatment, Mr. DeVito talked about the influence of the gangster again.

Mr. DeVito had just returned from the hospital where he had cardiac angiography. His doctors had shown him some of the X-ray films of his heart. Dr. B asked if the X-rays and dye studies had shown the presence of the gangster. Patient and therapist discussed the ins and outs of this. Mr. DeVito speculated that the gangster somehow wouldn't show up on the X-rays. The therapist pointed out that if he were a miniature person as Mr. DeVito had maintained, the gangster's bones would appear as densities on the films. Dr. B did not push this too far, and certainly did not try to "prove" that Mr. DeVito's ideas were irrational. Dr. B touched on this subject simply to explore the boundaries of Mr. DeVito's ideas, and also to add a quantum of uncertainty to a modest but developing sense of doubt in Mr. DeVito's mind.

It may be useful to acknowledge explicitly to the patient that patient and therapist have two very different views of reality. It is not necessary for the therapeutic work that both therapist and patient agree fully with each other, even about matters of "fact". The therapist can say that it is not his intent to pressure the patient to agree with his point of view, and that he hopes the patient and he can find a way to work together, and respect one another, even while important questions remain undecided.

It can happen that as time goes on, pieces and chunks of past experience and fantasy become clearer, giving at least some picture of how a delusion may have

been formed from its building blocks. It turned out that when Mr. DeVito was seven years old, his nine-year-old sister became ill and the family's attention focused upon her needs. The illness lasted several years and Mr. DeVito felt left out, overlooked and resentful. He recalled how his father had boxed with him as a child, and accidentally delivered a powerful blow to his chest, leaving the boy with "an aching feeling in my heart". When he was a child, his father's best friend, also a boxer, told him lurid stories about Cosa Nostra chiefs who exerted control and power over the lives of others in his native Sicily. In his current life, Mr. DeVito feels that his uncle is too much a part of his life, and has too much influence over him.

Now, of course, much of this history given by the patient might have been confabulated. Even if it were not, to present the patient with an intellectual solution to the cognitive riddle his delusion presented would not help much. The patient does not adhere to the delusion in the present because of faulty memory, or an inadequate capacity to translate symbols. There are powerful contemporaneous as well as historical motives that compel belief. But it may be helpful, as an addition to the general work, to trace the evolution of an idea with the patient. The patient's capacity for intellectual mastery can be a useful ally.

Ideas of reference

Ideas of reference can stir up torment. A person may believe that those around him are mocking him, ridiculing him, sneering at him or betraying him. The social environment becomes a dense misty wood in which his sense of safety and self-esteem can be ambushed without warning. Usually, such ideas are associated with vigilance, paranoia and guardedness.

Ideas of reference are often accompanied by the feeling that there is extra meaning in one's environment. Things do not happen either coincidentally or without some connection to oneself. Often, a person believes that events contain elliptical references in word or deed to himself. The people around them will not come out and say directly what they mean. They leave signs, suggestions and hints.

My impression is that the presence of ideas of reference is associated with a significant disturbance of self-esteem and the sense of boundary. The person often has an agonizing sense of worthlessness, smallness, oddness or badness. He believes that he has no clothes to conceal these disfigurements of his value, and that his own impression of himself is virtual public knowledge. The uncertainty and tension this creates is like a brooding creature, ready to attack. The person may act to resolve his disturbing doubts by confronting others about their opinions, beliefs, actions or comments to him to either reassure himself that they have not been malicious, or confirm that they have. All this may be done in an effort to master terrible anxiety. This solution, which is usually far out of step with social reality, makes matters worse. The person often *does* then become the object of notice, curiosity and hushed discussion.

What seems to add to the growth of ideas of reference is the person's own tendency to communicate in indirect, cryptic ways. He may lock his door to show that he does not want to be interfered with. He may come uninvited to a work meeting to express his hurt and anger about not having been invited to an unrelated gathering. He may act provocatively in psychotherapy, bringing limit-setting controls upon himself, instead of expressing his fear that he will choke his therapist.

Example: Ms. Chen – ideas of reference

Cathy Chen, the woman who was so prone to explosions of rage, had a new neighbour where she lived. Ms. Chen felt that this man was very intrusive. The newcomer enquired where Ms. Chen had lived previously, what she did for a living and so on, which made Ms. Chen suspicious and guarded. She felt that the man was loud and boisterous. All this made her angry.

In response, Ms. Chen put a note in her neighbours' mailboxes that informed them that all new tenants had to sit on the board of a major charitable organization to join the tenants' association.

As best her therapist could tell, the translation of this message was: "You know who you are. You are an uncouth, uncivilized low life. It is not my *credentials that should be inspected.* Your *qualifications will be scrutinized. If you want to associate with me, you'd better change your ways."*

Ms. Chen made no effort to speak to her neighbour directly, or to find some more specific, limited and neutral way to express her unhappiness and persuade her neighbour to be more respectful of her privacy. Because of her own poor social skills, because of her fear of retaliation or the danger of her own anger getting out of control, or because of her fear that she would be exposed as inadequate, she did not communicate directly with the new neighbour. Instead, she chose to aim a cryptic message at a diffuse target. The therapist's impression was that Ms. Chen believed that others felt and communicated in the same indirect way that she did. For her, the emotional airwaves were crammed with cryptic messages about others and about herself.

Of course, as with many psychotic phenomena, there is a grain of truth in the belief that others communicate to them cryptically. We all communicate indirectly some of the time both unintentionally and intentionally. Our facial expressions, tone of voice and behaviour reveal eminently decipherable messages that sometimes we do not intend to send. And we also sometimes choose not to be explicit with our intended audience: we often hint, imply and give clues. The tendency to scan for hidden meanings, and to send coded messages like Ms. Chen, is not wholly alien to normal functioning. But for a person with ideas of reference, what one might call the "deciphering" function is disturbed.

Such a person finds it hard to judge what is an intentional and what is an unintentional communication. He cannot gauge what the other person knows and does not know about the message he (the other person) is sending. He cannot judge, for example, how he should react when he correctly picks up unconscious

resentment on the part of another. Should this be considered part of life's normal ups and downs, and passed over unless it persists? Or should he feel attacked, and protect his safety and honour with a counteroffensive, or by breaking off the relationship entirely? Because the sense of boundary of these patients is disturbed, and because the person's needs for contact, safety and esteem are so urgent, these questions cannot be considered calmly and coolly, but seem to call for immediate and decisive action.

Example: Ms. Bennet

Ms. Bennet was leaving her favourite bakery. Traffic was bad due to a water mains leak. The saleswoman remarked, "Watch out for the traffic on 96th Street, Ms. Bennet. It's pretty bad." The patient was furious. Who did this person think she was to presume to tell her what to do? Ms. Bennet telephoned the owner and threatened to contact the Better Business Bureau if this happened again. Several weeks later, Ms. Bennet noticed that she had been overcharged on a utility bill. She wondered whether the saleswoman somehow had a hand in this and was retaliating against her for her phone call.

Part of what may contribute to the feeling of extra meaning in the environment is the disturbance in the patient's sense of distinct identity. For reasons discussed earlier (primitive projection, fusion of self and object images, inability to identify and conceptualize affects, etc.) the patient's sense of his own identity is diffuse and confusing. He is frequently unclear about his own motives and principles, and is equally bewildered about those of others. It is as if he has been placed in a Byzantine court, and has no idea what the various formalities and gesticulations signify.

Example: Ms. Chen

Combining deconceptualization with the absence of empathy for what is customary, Ms. Chen reported that her uncle once advised her not to let men "take her to the cleaners". It so happened that Ms. Chen's boyfriend one night offered to help her with her laundry. Was this okay? Is this what her uncle had warned against?

Working with a patient who has ideas of reference can be very challenging. The experience of the constant intrusion of others into the patient's emotional life feels threatening and intolerable. The patient's effort to protect himself often involves the use of very primitive forms of defence, which disrupt ego functioning and self-experience. These defences "victimize the ego" (Eissler, 1953) and often make matters worse. Patients feel that there is nowhere to find peace of mind and safety. This is yet another reason why attention to the therapeutic relationship and to the negative interpersonal experience is so important in work with these patients. The relationship with the therapist may be the only place where disorganizing emotions can be looked at and tolerated, and the only place where the experience of being impinged upon can be understood and eventually resolved.

Notes

1 Glover wrote, "The most successful resistances are silent, and it might be said that the sign of their existence is our unawareness of them" (1955: 54).
2 Sullivan wrote, "Everyone is much more simply human than otherwise" (1953: 32). He referred to this as the "one-genus hypothesis".

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6

MENTAL PROCESSES IN PEOPLE DIAGNOSED WITH SCHIZOPHRENIA

In this chapter, I will present some theoretical ideas about symbol and concept use in schizophrenia, the disturbance of the sense of boundary in these patients, and the dynamics of paranoia. I will present some thoughts about how psychological mechanisms and defences affect such psychotic psychopathology as concreteness of thought, hallucinations, delusions, disturbances of boundary, paranoia and looseness of association. Before this can be done, we must consider a plausible theory of the psychological interactions between thought, perception, affect and language in normal individuals.

The relationship between perception, affect, thought and language

Disturbances in people with a diagnosis of schizophrenia

Disturbances of symbol use and concept formation in schizophrenia have been discussed by numerous authors from varying theoretical perspectives. Some writers have focused on the equating of the symbol and the object symbolized (Klein, 1930; Angyal, 1944; Little, 1957; Searles, 1965). Other writers have also referred to the way such dysfunctional symbol use results in "concreteness" of thought (Little, 1957; Arieti, 1974; Searles, 1979). Disturbed symbol and concept use have profound effects on the psychotic person's capacity to perceive, comprehend, represent, imagine and communicate experience. People diagnosed with schizophrenia often live in a world of bizarre and private internal sensations and imagery. They may feel bewildered about the meaning of the social world around them, and may feel affectively isolated because of these disturbances.

Several writers have described the way in which thought in those diagnosed with schizophrenia appears to be either permeated by or at times replaced by body states or sensations (Freud, 1915; Searles, 1979). Searles called this *desymbolization*. In referring to a patient who, instead of thinking, experienced sensations, he wrote, "She evidently experienced it not as a figurative thought concept, but concretely as a somatic sensation" (1965: 582). Searles gives another example of

a woman who felt jealous in the setting of a romantic triangle between herself, the female hospital staff and the doctors. Instead of experiencing the *cognition* that she was involved in a romantic triad, she experienced the *perception* that the pupils of her doctor's eyes were triangular (Searles, 1979: 17).

I have provided a number of similar examples in Chapter 5.

When Ms. Chen felt that the therapist was having too much influence over her, she said that she felt that a dental instrument was poking at her skull. She believed that her therapist did not value her and that her self-esteem had been injured. Instead of realizing that her self-image had been affected, she perceived that her body had been altered.

Ms. Bender concluded that Dr. M was annoying her with his persistent questions. Instead of conceptualizing this as such, she "saw" a piece of an abrasive scouring pad next to Dr. M's chair.

In these cases, the patient's images, fantasies and thoughts somehow become transformed into somatic perceptions—they become *perceptualized*. Evaluations and affects become compressed into sensory "givens" that do not generate meanings or associations. Emotional responses to human interactions become cut off. This perceptualization has enormous consequences. The individual's experience of conceptual and emotional life becomes collapsed, flattened and compressed. Feelings and thoughts with all their meanings, depth and resonances become concretized into sensations and perceptions that were not designed to contain them. These sensations may become "uncanny" or "bizarre" in that they are not only exaggerated versions of sensory processes but, beyond that, they contain "surplus meaning" (Ricoeur, 1976). Bion (1957) refers to them as "bizarre objects". Searles wrote that the patient's "perceptual experience is grossly distorted" (1965: 581). Lacan said: "the non symbolized reappears in the Real" (1955–6: 86, quoted in Vanheule, 2011).

Certainly one consequence of the perceptualization of thought is a compromise of reality testing. Obviously, if a person is under the sway of bizarre and uncanny experiences, he becomes preoccupied and inattentive to the usual perceptual cues. Perception cannot be reliably used to signal *external* stimulation alone. The boundary between internal and external sources of stimuli is thus confused. Moreover, since concept formation (which to a large extent depends upon a social and consensual building-up of word meanings [Vygotsky, 1934; Stern, 1985]) is disturbed, the patient's link to conventional social meaning is disrupted. Accordingly, his capacity to evaluate the social criteria of reality is compromised.

This process is analogous to dream formation described by Freud (1900, chapter 7). The dream process attempts to render evaluations, meanings and emotions into *visual* images. These ideographs are then experienced perceptually. In psychosis, conceptual meaning is rendered not only visually, but also by hearing, touch, smell, taste, pressure and internal sensory experiences.

Schizophrenic thought is not only perceptualized or sensationalized,[1] it is also rendered concrete, and patients have difficulty imagining people, objects or experiences that are not in the here-and-now (Goldstein, 1944). In these people,

there seems to be a disturbance of the inner world of representation, distinct from perception, in which memory, wish, fantasy and image have room to develop and interact. Goldstein observed, "[There is] an absence of generic words which signify categories or classes" (1944: 25).

The development of perception, image and thought

How can the process of perceptualization be understood? The answer may lie in the path along which perception, image and thought are developed. This leads us to consider the observations of Spitz, Piaget and Vygotsky.

For Piaget and Inhelder (1969) and Spitz (1965), the first few weeks, if not months, of life are characterized by an inchoate sensory display of images and sensations that swirl around the infant. Piaget and Inhelder (1969: 70) refer to this as a "tableaux of reabsorbed objects".[2] At some point (within weeks or months, depending on the sense involved), out of this inchoate experience, certain perceptions coalesce. They stand out from their surroundings and become the focus of attention. In terms of sight, the infant is able to identify the boundaries or borders of the visual object, distinguish it from surrounding phenomena and attend to it.[3] Before this, says Spitz (1965: 59), "the *apperceptive* (bracketing) function is not yet available". He adds, "In this sense, the newborn does not perceive; in this sense perception proper is predicated upon apperception" (1965: 43). He continues, "Perception, in the sense in which adults perceive, is not present from the beginning; it must be acquired, it must be learned" (1965: 56). Goldstein (1944) also refers to the process of figure-ground discrimination in his discussion of schizophrenic thought.

The capacity for apperception, whether developed over time (Spitz, 1965; Piaget and Inhelder, 1969) or immediately available, is the basis for one of the child's most important acts of communication: pointing (Stern, 1985). In the act of pointing, the child designates a "syndrome" of perceptions that characterizes a delimited object, and refers it to the parents' attention. Later, the use of words (at first proper names, and later on class names) takes over the function of the motor act of pointing.

Now, in the infant, according to Spitz, there are two systems of perception. He refers to one as the coenesthetic system, and the other as the diacritic system. Coenesthetic experience has to do primarily with internal sensations from the viscera or proprioceptive organs. These sensations tend to be diffuse, unbounded and unlocalized. Diacritic sensations, by contrast, come from the periphery, and are more circumscribed and focal (they are *intensive* rather than *extensive*). After the development of apperception (bracketing), the infant possesses the capacity to form a perceptual or sensory image. These images may be visual, acoustic or tactile. While they may be associated with internal or external sensations, they are not themselves sensations. They are mental registrations of those sensations, or reproductions of those registrations.[4]

With the development of the mental image (often a visual one at first), mental life takes on a new character. For Piaget (Piaget and Inhelder, 1969), visual

images occur at about the same time as the use of verbal symbols; that is, at about eighteen months. Both visual image and verbal symbol can evoke, in the "mind's eye", the experience of a phenomenon that is not immediately present in time or space. Possibilities for conceptual thought, imagination, anticipation, memory and mental operations in general expand enormously. This is the time when reproductive memory first appears. For Piaget, reproductive memory is distinct from the earlier sensorimotor scheme. Before reproductive memory, the sensorimotor scheme is, in effect, its own memory.[5]

The child can now use a self-generated mental signal (an image) to stand for the perception of external objects and their relations as well as such internal phenomena as affect states, thinking and memory. The child becomes capable of imagination, fantasy, anticipatory thought and certain mental operations (Piaget and Inhelder, 1969). The child can now portray to himself events and objects that are not present in space and time. His mental representations may include images of the past or future, affect states and fantasies rather than external perceptions, or somatic sensations alone.

This image-forming function is extremely important and complex. For Piaget, it consists of an "internalized imitation" (Piaget and Inhelder, 1969). Within its own mental environment, the child actively reproduces certain perceptual or sensory experiences that once arose from actual external or internal physical events. Piaget says, "The image which occurs in the image-memory constitutes an *internalized imitation* (1969: 83, emphasis added). He adds that the image "may even elicit *sensations* in the same way as an imagined movement elicits muscular contractions" (1969: 69).

To put this in other words, the child creates sensory experiences in the form of images, which he uses as symbols for thought. The capacity for perception and sensation, which begins with a strong receptive component, is now pressed into service more actively, to generate sensory stimuli to be used as symbols. These sensory stimuli become the "media" of thinking, separate from thought content. Thinking can occur in a visual medium (i.e. as visual thought or dreams), an acoustic medium (i.e. words or verbal thinking) and perhaps other media as well. Each individual, in effect, is an "artist" who creates a plastic inner world out of visual, acoustic and other perceptions and sensations, adapted for the purpose of thinking.

One may wonder if those visual images that begin with external perception are in some way "transitional phenomena" (Winnicott, 1953). While they begin in some sense as "given" by the outside world, they are also taken over by the child in his imaginative play. This realm of "mental space" may be a "transitional space" in which the child exercises control over these sensory images. In fact, one may consider that the boundary between external and internal worlds consists not only of the skin and oral mucosa, but also the "space" between the sensory consequences of the object on the perceptual system and the active reproduction of these experiences. It is tempting to think of the mind as a transitional space in which the child omnipotently plays with images of reality in accordance with his own needs and wishes.

In psychotic people who show concreteness of thinking and poverty of ideas, this omnipotent play may be disturbed and the existence of this independent dimension of commentary upon reality is lost. The capacity of the child, and later the adult, to recruit perceptual and sensory experience in the service of thinking has a bearing on the psychotic person's perceptualization of thought. To perceptualize, a person must have a "perceptualizing apparatus"; that is, a mechanism that can convert mental contents into sensory images. In the image-forming process described by Piaget, we can find such a mechanism. This notion is supported by a good deal of recent neuroscientific evidence. Evidence from studies of brain-damaged patients and from PET scan studies of mental imagery suggest that when an individual tries to evoke a mental image of a past event, or an event in fantasy, he generates images in the perceptual nervous system (Farah, 1988, 1989; Kosslyn, 1988; Kosslyn et al., 1993). Other work has demonstrated that actively generated motor and perceptual sensory elements are also implicated in auditory hallucinations (McGuire et al., 1993; Waddington, 1993).

From concrete sensation to abstract thinking

If we are to understand, however, how the enormous complexity of abstract thinking can be compressed into concrete sensation, we must understand something about how thought evolves from concrete image to abstract concept. The work of a Russian psychologist, Lev Vygotsky, gives us some clues.

Vygotsky's work (1934) was based on empirical studies in the development of thought in children. He described the visual organization of concept formation. He described the progression of thinking in categories from "congeries" to concepts. At first, the child groups together anything in its visual field. The elements have a subjectively experienced relation, but this is determined only by their chance congregation in the child's visual field. Later, the child organizes his visual percepts in ways that have more to do with their cognitively thematic characteristics. Early on, objects may be classified on the basis of perceptual similarities (similarities based on size, shape or colour, etc.) or they may be grouped in "collections" based on their practical relationships (e.g. baseball, bat and glove). Vygotsky described other forms of linkage between objects (e.g. "chain complexes", "diffuse complexes" and complexes based on "pseudoconcepts"). The essential point is that the links are not made on the basis of cognitively thematic class concepts.[6]

Finally, the child arrives at a linking principle that abstracts a quality from specific objects and generates a *class concept* (a concept that designates a class or category). The class concept is not simply an arbitrary proper name attached to an object; that is, a sound that is taken as an acoustic property of the object itself before there is a representational world. A concept, by contrast, is an abstracted form (Langer, 1967) that defines a class to which elements may belong. Members of a class share some similar form (e.g. grandfather clocks, metronomes and swings are members of the class "oscillating objects"). The appreciation of "form" and the mental connecting of similar forms or patterns provide the basis of class

concept formation and abstract thought, whether verbal or logico-mathematical. Langer writes, "some kind of knowledge of logical forms . . . is involved in all understanding of discourse" (1967: 32). She continues, "The power of recognizing similar forms, i.e., the power of discovering analogies, is logical intuition" (1967: 33).

Now, as the child develops class concepts, he is also developing his use of verbal symbols (according to Piaget [Piaget and Inhelder, 1969], conceptual thought is not identical to verbal representation). Language is an enormous source of images and symbols that can be used for concept formation and communication. It accelerates the child's building-up of a representational world. Many authors have noted (Piaget and Inhelder, 1969; Stern, 1985) the way in which language is built up by interactions between parent and child. The child is taught about a social world of agreed-upon conventional meanings. A cat is called a "cat", not a "tree". Moreover, those experiences that are public, observable and easily attached to words gain privileged access to the lexicon. Some public language is also used to refer to internal states (emotions or thoughts) and to communicate these internal experiences between one subject and another. How one subject uses public language to refer to personal inner states may differ from person to person. There is no objective rule book for depicting inner experience. Says Goldstein, "Language in general in our civilization is more stereotyped and not rich in words to express the specificity of concrete situations" (1944: 29).

Thus, in learning verbal symbols, the child gains something and loses something. He gains access to the world of class concepts, to a world of cultural and historical meanings and to a verbally mediated picture of the internal states of others. However, in using public language to describe inner states, he may lose focus on his "unsocialized" capacity to experience the world in an immediate and fresh way, one true to his unique and idiosyncratic self. Langer refers to socialized conceptual knowledge as *knowledge about* in contrast with unique and immediate *knowledge of* (1967: 22). She uses the term *concept* to refer to socially learned abstract symbols, and *conception* to refer to an individual's private (and not necessarily verbal) way of seeing things (1967: 65–66). This distinction will be important later when I discuss the origin of delusions.

Affect

Before turning our attention once again to symptomatology in adults diagnosed with schizophrenia, it is necessary to say a word about affects. Obviously, the subject of affect theory is vast and very complicated. Here, I simply want to note the important relationship between affects and cognitions. A variety of primary affects, present at birth, have been identified. Among them are happiness, sadness, fear, anger, disgust, surprise, interest and shame. At first these reactions are mediated by primitive reflex-like mechanisms and have little to do with the infant's cognition or his conscious awareness of *meaning.* Rather, they are biologically rooted appraisal and response systems used in responding to internal and external

events (Lotterman, 2012). They serve appraisal, discharge and communication (i.e. signal) functions and biological adaptation. Later in development, affects become connected with cognitions. At this later stage, affects are elicited not only by sensory or perceptual phenomena such as hunger or touch, but also by cognitions (and fantasies) and their associated meanings. When the child sees the door open and an unfamiliar arm begin to enter, he develops a cognition about the arrival of a baby-sitter, and this means that a separation from his mother is imminent. (This process is not simply one of conditioning. Novel stimuli can evoke affective responses depending on the meanings with which they are associated.)

Later in development, affects themselves are increasingly structured by cognitions. The affects we are used to dealing with in psychotherapy and psychoanalysis are associated with cognitive appraisals. Envy, contempt, jealousy, pity and gratitude, for example, all come about because the individual makes a cognitive appraisal about the interpersonal world. This appraisal lies at the heart of the experience of meaning. If I am envious, for example, I must have a concept of an "other" who possesses objects or qualities that I do not have, but which I value. This is not equivalent in its structure to a more primitive "fight-flight" affect, which is more instinctive, biologically automatic and not so mediated by cognition and meaning. These more complicated affect states (e.g. envy and jealousy) can be understood as existential "stances" or "positions" taken by the individual in the face of an environment that has meaning. They are unlike earlier affect states that consist more simply of biologically inherited potentials for discharge and signalling that can be triggered by social releasers.

After this brief detour through image and concept formation, language acquisition and affect development, I would like to return to the psychotic patient and his symptoms.

Deconceptualization and its relation to concreteness of thought and hallucination

Much has been written about disturbances in the individual's affective life. Sometimes affects appear precipitously and seemingly outside his control. In more chronically ill people, affects may appear blunted (Bleuler, 1911) or absent altogether. Affects can be very disturbing to many people diagnosed with schizophrenia, whether they are their own or others, and many authors have commented on the techniques individuals use to defend themselves against emotion. Many writers have held that schizophrenic symptomatology, at least in part, serves as a defence against intolerable affects (Eissler, 1953b, 1954; Will, 1975; Searles, 1979: 16; Garfield, 1995).

One way in which someone can protect himself against painful emotion in a social context is to withdraw, and certainly many people diagnosed with schizophrenia are withdrawn. Another is to blunt or destroy the inner experience of emotion resulting in feelings of inner deadness (Eissler, 1953b, 1954). I would suggest that there is another method of defence that has far more extensive consequences

than social withdrawal or emotional flattening. I will call this defence *deconceptualization* (I will use the terms *deconceptualization* and *desymbolization* interchangeably unless otherwise specified).[7]

For those diagnosed with schizophrenia, affects, including painful ones, are stirred up by cognitive appraisals, which include abstract class concepts. These cognitions and their attendant meanings evoke powerful associations based upon both unconscious laws of association and conscious, conceptual relations. The resonances and overtones of concepts add intensity and breadth to our thought, and have powerful affective consequences. We experience emotion not only because of events that physically impinge on our bodies, but also because of events that may be far away or even imaginary but that have conceptual meaning for us. The entire realm of fantasy and its consequence for our affective experience depend on the fullness and intactness of conceptual experience.

Bion (1957) suggested that because psychotic individuals are subject to much emotional pain at the hands of external reality (that is, mainly social interactions), they attack the apparatus of awareness. He wrote that the person with schizophrenia "hates reality and all internal mechanisms that make him aware of it" (1956: 35). According to Bion, the person diagnosed with schizophrenia attacks his own process of forming conceptual links. It is not that individual thoughts are repressed, but that the mechanism of linking ideas and concepts together is itself attacked and dismantled. This dismantling renders schizophrenic thought vague, obscure and inchoate.

We can understand this "attack on linking" more specifically as a dismantling of the concept-forming capacity. The process of concept formation that Vygotsky (1934) described may be reversed. Thought may be progressively shed of class concepts or even specific proper names and is pushed *backwards into perception and sensation*. Although these perceptions are predominantly acoustic, or visual, they may also at times be tactile, olfactory or gustatory. The inner realm of thought, the "representational world", is flattened, compressed and robbed of associations and meanings. In Vygotsky's terms, class concepts are replaced by "complex" thinking, based upon perceptual similarities or functional relations. These principles of organization of thought may give way to even earlier "congerie" thinking, in which there is practically no thought at all, but merely visual apperceptions devoid of an organizing principle. Beyond that lies only jumbled sensory experience.

Do patients really experience these phenomena? I have given examples of the perceptualization of experience in earlier chapters.

Ms. Bender reported: "It is tough to get a hold of an idea, and bring it to my lips." Ms. Weiss said, ''My ability to find words to describe what I feel is gone."

Ms. Chen stated that she felt that her therapist had injured her self-esteem (i.e. self-image) and that this had changed the shape of her body. *On another occasion, Ms. Chen said that her uncle told her not to let men "take you to the cleaners". Her boyfriend had recently helped with her laundry, and she asked if that was okay, given her uncle's warning.*

The metaphoric link between the concept "being exploited" and the action "taken to the cleaners" had been broken. The class concept and thus the metaphoric function related to being "taken to the cleaners" had been lost.

I think examples such as these provide evidence of the loss of verbal symbols, the concreteness of thought and the substitution of perceptions for thoughts in psychotic individuals with thought disorder. Is there evidence that these processes are set in motion as a defence against painful affect?

Ms. Williams reported that for her, being homesick was "not an actual wound, it's worse than that. It's a wound in my feelings."

Mr. DeVito said, "It would be better to have a void than feelings sometimes."

Not only do patients report that affect is intolerable, but also that, somehow, their cognitive dysfunctions are related to such painful feelings.

Over a number of sessions, Ms. Weiss told Dr. E of intense and murderous feelings directed toward Dr. E and others. The intensity and vehemence of this hostility was frightening. After having "come alive" as she discussed her homicidal wishes over several sessions, her demeanour suddenly changed. Once again, she became torpid and listless, and almost appeared sedated. She reported that she felt her mind had calcified and said, "My mind doesn't work well enough for me to get mad." Dr. E was persuaded that the patient's earlier hostile state was very frightening to her, and it appeared to Dr. E that the patient had "dismantled" her thinking to avoid this painful affect. Somewhat later, this same patient stated that there was really nothing in her head anymore, just a "fog".

Do individuals' bizarre or uncanny perceptions and sensations really contain surplus meanings left over from conceptual thinking? In Chapters 4 and 5, I have given a number of illustrations of perceptions that, when explored, seem to yield up affective meanings. The example of the visualized "scouring pad" given earlier in this chapter is prototypic. On some level that was not conceptualized, Ms. Bender felt that the therapist was annoying. This belief was not experienced as a conscious concept. The patient *perceived* a scouring pad next to Dr. M's chair. Had Dr. M not enquired, the patient's belief that he was annoying might have been lost to awareness. When therapist and patient explored the details of her sensations, and actively applied word concepts to them, there unfolded affect-laden words such as "abrasive", "irritating" and "pushy". Finally the image of an annoying person appeared and Dr. M could link this with the patient's experience of him.

This formulation of desymbolization, deconceptualization and perceptualization is important because it provides a rationale for treatment technique. It suggests that we should examine the patient's behaviour, speech, sensations and perceptions in detail. Even if speech is idiosyncratic, or the perceptions not consonant with the socially accepted version of reality, we assume that the patient's words may contain bits of fragmented conceptual thought. Our effort is to help the patient focus upon these phenomena, and describe them in as much detail as he is able. In the process, we call upon the patient to use skills of attention, focus, image formations, naming and concept formation to explore these uncanny experiences.

These skills may have, for defensive or developmental reasons, fallen into disuse. Or, for reasons other than defence,[8] they may have become unavailable to the patient. In either case, via techniques such as naming, enlargement and disclosure of the countertransference, the patient and therapist may be able to re-find lost affects and meanings. This process can help the patient, if he is so motivated, to take a step back toward the world of socially shared conceptual meaning.[9]

Disturbances in the self-object boundary

Since the beginning of psychoanalysis, many theorists have held that, at the earliest stages of life, the experience of boundary between self and others is undifferentiated (Freud, 1930; Fairbairn, 1941; Fenichel, 1945; Weissman, 1958; Jacobson, 1964; Spitz, 1965; Mahler, 1968; Schafer, 1968; Piaget and Inhelder, 1969; Kohut, 1971; Kernberg, 1975, Loewald, 1980). In their attempts to understand schizophrenic experience, many writers have referred to disturbances in discriminating between self and other, and inside and outside (Freud, 1911; Fairbairn, 1941; Fenichel, 1945; Jacobson, 1954; Winnicott, 1960b, 1962; Searles, 1965, 1979; Mahler, 1968; Kernberg, 1975).

Authors have differed in their understanding of how the disturbance of boundary comes about. Some understand it to be a regression to an earlier state of undifferentiation (Jacobson, 1964; Mahler, 1968; Searles, 1965, 1979). This may occur because of a breakdown of autonomous functions of the ego (Hartmann, 1953; Marcus 1992), which leads to a collapse of reality testing and a dedifferentiation that is experienced passively. Or, it may come about as a result of active defences involving fantasies of fusion and merger of self and object representations (Jacobson, 1964; Mahler, 1968; Kernberg, 1975).

Stern (1985) has suggested that there is no early developmental state of merger or fusion, but from his earliest days, the infant has a rudimentary sense of himself as distinct from others. Stern believes that experiences of fusion, when they occur, arise only after the achievement of a capacity for active fantasy.

Whether they first originate in earliest development, or in later fantasy productions, the sense of a confused boundary between self and other is prominent in the symptoms of psychotic patients.

A 50-year-old man came to the clinic one day without an appointment. He wanted to see his therapist, Dr. O, and was clearly upset. Dr. O asked him why he had come. He replied, "You know why I'm here, Dr. O; don't play games with me." Dr. O told him that, in fact, he did not know, and could not figure out what the patient was thinking without his telling him. He answered, "Then how did I know to come here today? I knew you wanted me to come. Why else would I come all the way from downtown, when I had better things to do?" Clearly, for this man, the boundary between his thoughts and Dr. O's thoughts was confused.

Ms. Chen often felt that her therapist had entered too far into what she called her "personal space". When this happened, she said, she felt (she had a near-sensory perception) that her therapist was pinching her ear with tweezers. Apart

from her perceptualizing the image of intrusion, this sensation demonstrates Ms. Chen's fragile sense of coherence in space. She did not have an inner mechanism to somehow establish an effective barrier against the experience of invasion. It is this function, which involves both identifying inner states as belonging to the self and outer influences as remaining external, that I have referred to earlier as the sense of boundary.

What is the mechanism by which this sense of boundary may become disturbed in psychotic states? Biological factors could play a role, and defects in a neurophysiologic "stimulus barrier" could affect a sense of what is internal and what is external. In this regard, investigators have theorized about defects in ego functioning (i.e. "regressive dedifferentiation") and defensive wishes for fusion that spring from conflict. Other somatic factors might also come into play. Here, I would like to focus on a psychological mechanism that may play an important role.

As I suggested in Chapters 4 and 5, the experience of an intact boundary may be partly rooted in interpersonal affective experience. If an individual finds that his own emotions or thoughts are powerfully influenced by the behaviour of another, one may speak of an impaired boundary. For example, if a child's feeling of tranquility is utterly disrupted by his mother's irritable mood, one may say that the child's inner world has been intruded upon by the adult. Some degree of this, obviously, is part of everyday life. But if it occurs with excessive force or frequency, the child may feel that there is no effective brake on the mother's capacity to influence his inner state. He may experience this vulnerability as an absence of boundary.

Stern's work (1985) helps us understand this mechanism. Stern describes the experience of inter-affectivity after the child has developed an intersubjective self. During this period, the child has a powerful need to "know and be known" and deliberately seeks the sharing of affective experience with another. By means of gestures and vocalizations, the child and his mother send signals to each other. If these signals are reasonably well matched in form, intensity and other characteristics, a sense of "interpersonal communion" develops in which the child feels that his mother has, in some way, "understood" his subjective experience. Stern believes that the mother must match the formal qualities of her child's experience, what he terms the "vitality affects", to signal a matching. *Attunements* is the term Stern uses for the mother's responses that mirror the form and intensity of her child's inner experience.

Now, if the mother is motivated and able to perform attunements that approximate her child's inner state, the child experiences a "going on being"(Winnicott, 1960b). If, however, the mother's gestures do not match the child's inner state, a "misattunement" occurs, and the child's ongoing subjective experience is broken. This interruption may be felt to be very painful by the child. Instead of a satisfying "going on being", the child feels that both the flow of his own functioning and his communion with the mother have been interrupted. Instead of feeling understood, he may feel very alone. Or he may experience the mother's mismatching as a coercive attempt to control or change his inner state. If such misattunement

persists, the child learns that intersubjectivity may lead, not to pleasurable sharing, but to a painful loss of inner peace and continuity.

If misattunements are too far off the mark, they may have less impact on the child. In effect, the child may brush them aside and ignore them as being unrelated to himself. If, however, a misattunement appears at first to match the child's vitality affects, it can "gain entry" into the child's experience, only, finally, to disrupt the child's sense of well-being. The experience of faulty attunement may feel coercive and controlling. He may feel that the parent does not want him to feel his own feelings. Under the pressure of his need to reestablish an interpersonal communion, he may try to comply with the pressure he perceives. Thus, he may tone down his joy, he may feign happiness when sad, he may pretend pleasure when there is none. In effect, he may develop a "false self (Winnicott, 1960a). His actual subjective experience, his "true self", may be driven underground and become secret. Stern (1985) points out that the "not-me" of Sullivan (1964) may correspond to subjective states that have been disavowed. It should be noted that, according to Stern, if the mother matches the child's inner state too completely, or too frequently, the child may experience a kind of psychic transparency, in which he believes that his thoughts and feelings are immediately accessible to the parent. In this case, there is no privacy.[10]

It is very tempting to connect Stern's discussion of the child's intersubjective experience with Klein's notion of projective identification (Klein, 1946). For Klein, the individual who uses projective identification attempts, in fantasy, to enter the mind of the other, often with the wish to control them or destroy them from the inside. The child who experiences misattunements may feel like the victim of such an attempt. According to Stern, the child experiences these misattunements as coercive efforts to enter his mind and control his inner experiences. It is not a great speculative leap to imagine that in his effort to adapt, the child may wish to turn passive into active, and begin to entertain fantasies of entering into and controlling the minds of others. This early interpersonal experience may also be the basis for later delusion of control and thought broadcasting (Schnieder, 1959). It may also help us to understand delusions concerning the capacity of others to read one's mind.

This detour through Stern's work sheds light on our understanding of the sense of boundary. While we may or may not believe that neurophysiological factors affect the discrimination between self and others, or inside and outside, it does appear that early interpersonal experiences can influence the subjective experience of a boundary. The child's experience of having his thoughts influenced or known (i.e. "thought transparency") is similar to the psychotic patient's experience of thought insertion or thought withdrawal. It reflects a concern that there is no *cognitive* barrier between the contents of his mind and other people's perceptions. The sense of coercion related to misattunements may generate a concern that there is no barrier between his own ongoing affect states and the affective intrusions of others. Even without the concept of attunement, we know that others can have profound effects upon our moods and feelings. If we cannot somehow

mitigate the impact of these effects (if, for example, we cannot help feeling guilty after a parental criticism, or we cannot help feeling envious when a colleague discusses an achievement, etc.), then functionally, there is a reduced sense of boundary.

Example: Mr. Tilden – intrusion into the self-object boundary

Do these formulations about the sense of boundary apply in the clinical setting? I think there is evidence that they do.

Mr. Tilden came in from the waiting room. He said that he had had a very important dream and had remembered all the details in the morning, but now had forgotten it. He started to talk about something else very briefly, then paused and said that he didn't know what else to say. The therapist asked how he understood his forgetting his dream. The patient became furious. She (the therapist) did this all the time, he said. Did she want *to injure him? Why was she always trying to force* her *ideas of what they should talk about on him? Did she think the session was there for* her *benefit? He said that the therapist was "toying" with him and "cornering" him. He declared that now he didn't trust her. He went on like this for perhaps fifteen minutes. Finally, he said, "I can't afford to indulge myself in being so angry with you because I need you on my side."*

This patient's rage at the therapist could be understood as a reaction to a feeling of an interruption of his "going on being" and was an "impingement" in Winnicott's terms (1960a). He experienced her as intrusive, self-centred and even actively malevolent. In referring to her "cornering" him, it seems he was making reference to what Stern calls the "coercive" effect of misattunements. In his view, the therapist's image of him was too narrow for his sense of full subjectivity to be comfortable with, and he would not accept a too restrictive definition of his self. The patient appeared to feel that his therapist had violated his sense of integrity in some way. Clearly this feeling was consistent with a lifetime of feeling "squelched" by family and friends.

Seemingly, Mr. Tilden had three options. He could withdraw from interpersonal contact; he had done this many times before, falling into prolonged silences. He could submit and act as if nothing had happened, developing a false "cooperative" demeanour. Or he could actively protest. This last option may have been the most growth-promoting, and in this instance, was the one he chose.

Another important feature of Mr. Tilden's experience was his sense of need and impotence. He had an unpleasant choice. He could continue to stand by his sense of self and protest, risking a loss of contact or communion with the therapist. Or, he could "disavow" a very meaningful self-experience to maintain contact. Often he experienced this last choice as humiliating. He felt shame over being such a "sucker" and felt that he was "weak".

Mr. Tilden felt the choice between humiliating surrender or defiant aloneness to be either/or, and part of the therapeutic work was to help him understand that the therapist's "misattunements" were not intentional, and that, in any case, he

was free to stand by his sense of self and protest when he needed to, and that maintaining a relationship did not mean he had to abandon his sense of integrity.

Mr. Tilden's belief that he had to adopt a "false", compliant self to maintain contact with his therapist had a variant. On another occasion, he said he wanted the *therapist* to be nice, so that they could get back to having a good relationship. Why did *he* always have to submit? Instead of denying the meaning of his own self-experience, the patient wanted the therapist's position to change. Instead of a kind of "masochistic merger" based on a false self, he wanted a change to come from the therapist. One might wonder whether this mechanism, at least in part, lies behind what has been termed "omnipotent control" (Kernberg, 1975). The patient desperately wants to maintain positively toned feelings toward the therapist. If he feels a misattunement, he has two choices: he can develop a submissive false self, or he can try to get the therapist to act in such a way as to not stir up more misattunement. The patient, clearly, will have very specific ideas about how the therapist should behave so that he, the patient, can return to a subjective feeling of attunement.

Klein (1946) and Kernberg (1975) believe that projective identification results from an intrapsychic fantasy. I am suggesting here that projective identification may have an interpersonal origin as well, arising in the context of one person's affective impact on another (Lotterman, 1990).

It is important to note that the disturbance of boundary discussed above does not necessarily imply a loss of reality testing. The capacity to discriminate between self and other, or between internal and external sources of perception, or the capacity to appreciate the social criteria of reality (Kernberg, 1975, 1984), are not necessarily frankly impaired when there is a sense-of-boundary disturbance. In its extreme forms, however, the experience of coerced inner states or of transparency may contribute to intense feelings of an interpersonal lack of control and lack of autonomy from emotional influence. These feelings are not, in themselves, psychotic. However, their deconceptualized and perceptualized representation in the form of the experience of a common skin, or feeling the other person's pain, or that thoughts are being inserted or withdrawn, does typify the psychotic experience of self-object dedifferentiation.

There is a core of interpersonal affective reality in the psychotic experience of the loss of boundary. But this interpersonal experience might not lead to the loss of the self-object distinction that characterizes psychosis, were it not for the form in which it is represented. This form arises from the process of deconceptualization and perceptualization. It is these processes that result in the concrete, subjectively felt experience of dedifferentiation and merger.

Paranoia and the sense of boundary

I think that what has been said above about the sense of boundary bears directly on the experience of paranoid states. The sense of a shattered boundary and the vulnerability of the subjective sense of self lies at the centre of the paranoid

individual's experience of himself, and contributes to his feelings of fear and rage. It seems that for some paranoid people, it is neither acceptable nor even possible to develop a false, compliant, social self. Perhaps for such individuals, hiding a "true" self away is not enough to protect against a feeling of annihilation. Perhaps the integrity of such a hidden true self is felt to be too precarious and unreliable. Whatever the case may be, such people react to impingements or intrusions on their self-integrity with violent rage.[11]

Set against this is the individual's need not only to be *a* self, but *him* self. This conflict was described by Mr. Tilden, who had a number of paranoid trends. Unable to fall back on a false-self solution, the individual can either withdraw or protest. But if the conflict is more intense, it may take on a more overtly paranoid form. Objects may be experienced as intensely impinging, seductive, dysregulating and ultimately shattering of the individual's sense of cohesion. In this case, the person experiences an urgency about escaping a form of agony (Winnicott, 1962, 1963). The forms of withdrawal and the forms of protest are correspondingly intense. Withdrawal may take the form of an abrupt and profound social isolation.

Ms. Chen had very little contact with anyone. Her one contact, apart from the relationship with her therapist, was a boyfriend, with whom she had stayed for several months. On one occasion, he made an unwanted remark. The patient reacted with rage. She abruptly and permanently ended the relationship with him, with her employer and with her therapist. It seemed that her experience of violation and impingement was so intense that her interpersonal world had to be reduced practically to zero to protect her fragile sense of self.

Ms. Chen was very suspicious of transference interpretations. She felt that her therapist was being "too personal" and brushed aside clarifications and interpretations. Her therapist understood this not to be evidence of an incapacity for transference, but of a very particular transference disposition. The patient was frightened that the therapist would somehow take control over her. She experienced the meaning of this in perceptualized form as a dental instrument poking at her skull, or copper wires attached to her body.

Ms. Chen's withdrawal stands in contrast to the reciprocal reaction of rageful protest. (Actually, her ending her relationships with her boyfriend, employer and therapist expressed both withdrawal and protest.) Ms. Chen often reacted with rage when she felt that her "personal space" had been invaded. Similarly, Mr. Martin responded with fury when he felt that his therapist didn't understand him or care about him, or if he felt that his therapist was not on his side.

The response of rage accomplishes several things and may be the preferred one. First, it creates a distance that may bring relief from a sense of impingement. Second, it may help consolidate a fragile sense of self. Mr. Tilden said, "Not agreeing with you is the only thing that keeps me sane." Third, it can be a response to a sense of powerlessness. Aggression may naturally call up senses of self that involve activity, potency and control. Finally, an ongoing hostile relation establishes distance, but also maintains (even if distantly, and only in fantasy) some sense of ongoing connection (Auchincloss and Weiss, 1992). The thread

of interpersonal communion, even if only in fantasy, and even if attenuated and charged with anger, is still maintained.[12]

Certain particular cognitions may accompany the sense of impingement. Certainly, it would consolidate and rationalize the individual's experience for there to be a personified "impinger". If the individual feels that his inner affective state is being robbed or stolen, this would understandably be complemented by the notion that there is a robber behind this process. Ms. Chen reacted angrily to the sense that her therapist had been coercive and hurtful. She said, "Do you want me to be unhappy?" The idea that her therapist was motivated to harm her had appeal. It may be that it is difficult for patients, or people in general, to believe that their agony has been caused by accident or by chance. Certainly, Piaget (Piaget and Inhelder, 1969) tells us that the appreciation of chance is a late event in the development of thinking in the child.

The formulation described above certainly does not rule out the possibility that part of the patient's sense of a hostile other stems from his own projected rage.

Loss of meaning, loss of identity and loss of contact with the social criteria of reality

I would like to comment on that aspect of reality testing that Weissman (1958) referred to as the "corroborative element" and Kernberg (1975) referred to as the "social criteria" of reality. Kernberg identified the capacity to empathize with these social criteria as one of the cornerstones of intact reality testing. It involves the individual's capacity to appreciate the point of view that other observers have about him.

It would seem that this capacity can only arise after the development of language, which provides a consensually developed, public and therefore "official" set of meanings (Vygotsky, 1934; Lacan, 1955–56, 1959; Langer, 1967; Stern, 1985). Implicit in the syntax and vocabulary of language is a conventional viewpoint about objects and events, including human behaviour and experience. According to Vygotsky (1934), the child can only begin to develop an "objective" view about himself after he has understood language and its socially developed meanings. Language serves as a transition between the outer world of defined and delimited cultural meanings and an idiosyncratic inner, private world of perception, sensation, affect and image. According to Vygotsky, the child first learns "public" language ("external speech") and only later applies it to his inner states ("inner speech").

When verbal thought is compromised, as it is in some psychotic states, when concepts are transformed into sensations or perceptions, the individual loses contact with the social and cultural point of view. He no longer participates so fully in thinking with the point of view of the "average expectable member" of the culture. As a result, his world becomes more private and more autistic. His appreciation of the *social* criteria of reality is compromised. Lacan's notion that the Name of the Father is not installed in psychotic patients is based on a similar idea.

There is a second factor that may contribute to the loss of empathy with the average social viewpoint. Because in psychotic states the sense of a cohesive self is disturbed, the individual may have little experience of the feeling of a healthy, coherent self. His fears may be so powerful, his sense of vulnerability so urgent and his need to act defensively so preoccupying that he may have little understanding of what an "average expectable self" feels like. It may therefore be quite difficult for him to empathize with the experience of the relatively healthy selves who define what behaviours and affects constitute conventional "normality".

Ms. Chen, who was quite isolated and who experienced her sense of self as extremely threatened, frequently seemed to have little or no idea about why people acted as they did. She would continually ask her therapist why colleagues, acquaintances or family members behaved in a certain way. Questions such as: "What do you think he meant?" and "Why did he say that?" were a regular feature of the meetings. It did not seem to be a contradiction to Ms. Chen to also ask her therapist what she should do in many cases. Despite her extreme sensitivity to coercion and invasion of her "personal space", Ms. Chen's bewilderment about how and especially why people functioned in the social world led her to invite her therapist to be a kind of anthropological guide to an exotic and bewildering social world.

This sense of living in a strange land is portrayed in Kafka's *The Trial.* K seems utterly bewildered about why his accusers have set upon him, and seems out of touch with and uncomprehending of the behaviour of those around him. They have profoundly disturbed his sense of "going on being". He seems unable to understand their language, or to put himself in their shoes.

Delusions: concepts and conceptions

An understanding of the collapse of the inner realm of conceptual thought into concrete images, sensations and perceptions, and the isolation from the world of social meanings that this brings, may help us understand something about the nature of delusions. By definition, delusions are beliefs that contradict the commonly held views of material reality (e.g. the Earth is made of cheese) or social reality (e.g. Elvis Presley is the President). In discussing the loss of empathy with the social criteria of reality, I mentioned that the inner realm of concept and abstract image had collapsed. When this occurs, the multitude of concepts about social and personal issues that the individual has also collapses as thought becomes concrete, perceptualized and sensationalized. Having lost verbal concepts and their structured social meanings, the individual must fall back on presocial, prelinguistic forms of thought—idiosyncratic personal images. Vygotsky (1934) called this "autistic" or "alogical" thought. In referring to schizophrenic thinking, Kasanin said, "Things have a personal, rather than a symbolic value" (1944: 43). In referring to the public rather than the private function of language, he wrote, "Language in our civilization is more stereotyped, and not rich in words to express the specificity of concrete situations" (1944: 29). Kraepelin (1902)

noted that psychotic patients express "complicated, morbid ideas for which no words exist".

Suzanne Langer referred to the distinction between public and private image when she described the difference between concept and conception (1967: 65–66). The concept has a publicly shared, delimited meaning. The conception, by contrast, is a private image built up out of personal experience which may or may not find expression in public concepts. It corresponds to what she called "knowledge of" rather than "knowledge about". Our *concept* of 90 degrees Fahrenheit may have to do with a thermometer whose mercury has risen to a certain level. Our *conception* of such heat may have to do with a particular visual image of shadeless sunlight, or air shimmering off a hot pavement, or the singular sensation in our mouths when we are thirsty.

It is certainly true that private conception and public concept interact. Poets, creative writers and patients among others try to find ways to express their private conceptions in public, verbal terms. On the other hand, we have all had the experience of discovery when a routine public concept that we have heard repeatedly is connected with a private, immediate experience. We experience an "insight", and the concept comes alive.

Now, when the psychotic individual's conceptual world collapses, it may be replaced by his earlier conceptional world. He may experience images and meaning essentially private to himself. When these meanings replace a public concept, the ground may be prepared for a delusion. We all have private conceptions about our experience, many of which are, by definition, unconscious, because they have limited access to words. These are the images that are subject to the unconscious primary process described by Freud in *The Interpretation of Dreams* (1900). These images undergo characteristic transformations that include displacement, condensation and symbolization. When an individual substitutes his conception for the cultural concept, and when he attaches a *feeling of reality* (Frosch, 1964)[13] to this conception, a delusion has been formed. His conception is not experienced as a subjective point of view, or a personal slant, but as objectively true.

Mr. DeVito believed that a gangster had entered his heart. When actively psychotic, he believed that this gangster would control his behaviour and bring destruction on him. Over the course of several years of work, the following memories emerged: shortly after he started to attend school, he began treatment with a brace to correct congenital hip dysplasia. Sometime after, his sister fell ill and much of the family's time and resources were devoted to her. Still later, a family friend told the patient lurid stories about the Sicilian mob. Mr. DeVito's ongoing experience of his aunt was that of an involved, even loving, but intrusive and smothering presence. For many years, he lived with his aunt and uncle when he was a patient. His aunt cooked his meals, and worked as a secretary to support him.

On one level, Mr. DeVito understood that his aunt was "only" a person, and that even if she was overinvolved, she loved the patient in her own way. This was the level of social *concept.* On another level, he had a *conception* of his aunt as

an unstoppable invader who made him feel claustrophobic within his own self, whose presence felt so expanded that it threatened his sense of a cohesive self. In this conception, the images of the mechanical disruption in his sense of going on being (the brace) and the fragile cohesion of his self were linked to a later disruption of his feeling of interpersonal communion and affectivity (his feeling of being displaced by his sister as the focus of his parents' attention). This, in turn, was linked to the frightening experience of his uncle's Cosa Nostra stories. These links are nothing unusual. We all have such irrational linkages in our unconscious conceptional thought.

My hypothesis is that what brought these images to the forefront was the breakdown in the availability of conceptual thought, which permits a link to external human objects. These grounding human objects, when internalized, permit the soothing of fear, the dampening of disintegrative anxiety and the reduction of primitive defences (Klein, 1946). Thus, conceptual (abstract) thought can symbolically help the individual maintain an affective link to the world of humans. With the loss of *conceptual* links, the patient's *conceptional* links impressed themselves more forcefully on him. In the absence of social concepts, the individual's autistic conceptions hold sway. The soothing internal link to the world of humans fades away, and the individual feels that there are no internal good images of humans. Paranoid and schizoid fears of dissolution, disintegration and a crescendo of unbearable anxiety may begin to swell.

The feeling tone of reality

Still, no matter how anxiety-generating, these irrational private links would remain "overvalued ideas" if they weren't connected with a feeling of reality. The origin and function of the feeling of reality is complex, and not something that can be discussed here at great length, but it seems to be vital for the evolution of the species. Clearly, it is adaptive for living organisms to connect a particular feeling tone to external perception, and even internal sensation. External dangers and urgent internal needs must be attended to and not confused with fantasy, illusion or "hypochondriacal" experience. In humans, the function of the "feeling" of reality is complicated by the existence of a sensory-based, representational life that evolves from perceptions and sensations, which are then used for thinking; that is, visual, acoustic and other images. Human beings must discriminate between internally generated images, fantasies, memories and concepts on the one hand, and perceptions and sensations on the other. Hartmann (1953) refers to this process as "inner reality testing".

The fact that mental contents exist in such a panoply of images arising from such different sources constitutes an Achilles heel for the feeling of reality. If sensations and perceptions were the only mental content, mistakes in the feeling of reality and the loss of reality testing would not be so much an issue. This may be the case for those animals who have relatively little symbolic mental life, and who can ill afford to lose contact with reality. Since human mental experience goes

far beyond sensation and perception, opportunities expand for confusing fantasy, mental image and perception.

Clearly there are also psychodynamic reasons for attaching a sense of reality to nonreal phenomena. We are familiar with this in its negative form in the defence of denial, when a piece of external reality is detached from a feeling of reality and ignored. We treat the person or event as if it did not exist. Similarly, we can treat our own inner experience as if it is not real, and detach it from a feeling of reality.[14] Clinically, we understand that denial and disavowal are used defensively to resolve conflict.

Psychotic people may accentuate the feeling of reality (rather than minimize it as they do in denial) as a defence against conflict. When under stress, Mr. DeVito felt very much alone, very much in need of being taken care of and very much in need of rescue from coercive, invasive others. He felt vulnerable, helpless and controlled. One may hypothesize that because of the loss of a conceptual frame of reference, and because he needed to enlist the help of others, the conception of the brace-abandonment-aunt-invasion of the self-family friend-Sicilian-mob-gangster that was performed in his fantasy became attached to a feeling of reality. In so doing, the patient felt there was good reason to make an urgent appeal for help and intervention.

One may speculate that just as human beings can reproduce visual and acoustic sensations to use for thinking, so they can reproduce the "feeling tone" that usually accompanies external perception or internal sensation. All perception and sensation must have a distinctive impact on the central nervous system that signals their existence, their "isness". This feeling tone or "isness" sensation goes a long way to establish the "real existence" of a phenomenon (Weissman, 1958; Frosch, 1964). The cognitive elements of reality testing may corroborate and reinforce the feeling of reality, but are distinct from it. The results of this cognitive aspects of reality testing, like most psychic phenomena, can be ignored, denied or rationalized as needs warrant.

When the conceptual world of the psychotic person becomes concrete, meanings appear to vanish, but as we have seen, they are not obliterated entirely. Sometimes they may return in a perceptual or sensory medium in the form of bizarre or uncanny perceptions or sensations. Or they may return as a distorted cognition albeit in a nonconceptual (i.e. non-class concept) way, in the form of ideas of reference and delusions. The poverty of meaning that is such a feature of the inner life of persons diagnosed with schizophrenia is the obverse of the surplus of meaning he experiences in ideas of reference and delusions.

The concretizing of thought may play a role in the phenomenon of "psychotic transference" described by Little (1957) and Searles (1965). The patient who experiences such a transference does not distinguish between the therapist and the image of a figure from his past. This may occur because there is no "past" as an ideational, nonsensory mental content to which to refer when the conceptual world becomes concrete. The patient knows that an intense feeling is being experienced in the present. Yet he does not have a recoverable past to which to refer

this feeling. He cannot say, for example, "I feel very tense and frightened like I did when my father criticized me. Moreover, I remember that, earlier today, I had a dream about my father yelling at me. I must be carrying this feeling around with me wherever I go, and I can see that my therapist is not the one evoking it in me." Unlike such an individual, the psychotic person only knows that he is in the presence of his therapist, and that he is experiencing this powerful emotion.

Ipso facto, the therapist is implicated in this state and is thought to have evoked it. The patient has thus confused past with present, and "symbol" with object. I place the term *symbol* in quotations, because, in fact, the patient is not truly capable of symbolizing at this point. The fact that psychotic people may have few concept-based images of the past, and react as if the present is the only psychic reality, may be the basis of the observation that they are not capable of working with transference (or do not form transferences).

The role of culture in calming basic existential anxieties

Yet another dimension to the formation of delusions has to do with the individual's relationship to the larger culture. The formation of delusions sits at a crossroads between individual psychology and the broader culture. Culture, no doubt, serves a variety of functions. But it plays a crucially important role in structuring individual psychology. We are born with the potential for anxieties of all kinds: anxieties about being fed and sheltered, about being abandoned, about being sufficiently loved, about being small and helpless, and about knowing too little to survive on our own. These anxieties serve a necessary function: to alert and mobilize us and our caretakers when basic needs are in danger of not being met.

Some of our anxieties have to do with basic existential questions: Who am I? What do people want from me? What is my purpose in life? What is death? What do I deserve and what do I owe to others? What is right and what is wrong? How must I behave so that I can fulfil my own nature and still be accepted by the group and by my own conscience? Young children depend on their parents to answer these questions, and, early on, these answers are accepted without much debate. Such existential questions are settled by identification and obedience.

In Western societies, these questions typically become more acute during adolescence, when children prepare to leave their structured life at home and enter the wider world. The "culture" of the home will soon be replaced by the broader culture and adolescents search their souls to decide what is expected of them and what kind of self they wish to be. At this point, many of these existential questions take on compelling significance. To avoid disorienting anxiety, some kind of answers must be found. As Erikson (1950) pointed out, this is a time of rapidly shifting identifications in which adolescents try out various styles and ideologies.

Part of the function of the culture is to provide a comforting structure that helps with uncertainties that have no ready answer. The psychological power of religion, political beliefs or any other "ism" probably rests on such a function.

Whether it makes empirical sense or not, these ideologies support the survival of "faith" in life—faith that we will live until tomorrow, faith that personal loss will not be unbearable, faith that the future will not be too chaotic or painful. Some of these beliefs may be transitional illusions that provide a comforting sense of control over the many vulnerabilities of human life (Winnicott, 1953). In most cultures, there are enough available ideologies to suit most temperaments and in the end many people find comfort in one or another.

People with psychosis are often left out of membership in the most common ideologies. As Lacan explained it, the Name of the Father is not installed in them (Lacan, 1959). The rules of the culture and its meanings are not instantiated sufficiently to shield the psychotic person from the strain of facing basic existential questions all on his own. The reasons for this may vary. But its consequence is that the psychotic individual does not have the comfort of basking in cultural assumptions and the emotional support that accompanies them. They experience a kind of acute adolescence without end, searching for answers to questions that often have none.

In the absence of a cultural ideology to soothe themselves, people with psychosis must fall back on their own imaginations. They invent idiosyncratic answers to life's profound dilemmas and found their own private religions and ideologies to cope with them. Just as "normal" members of the culture cling tenaciously to belief systems that explain life, its suffering and its meaning—Christianity, Islam, Socialism, Capitalism, Liberalism, Conservatism, etc.—so psychotic individuals cling to the private belief systems they have felt compelled to invent. Delusions represent the private and idiosyncratic ideologies that structure the lives of individuals diagnosed with schizophrenia.

Looseness of association and over-abstraction

The clinical phenomenology of looseness of association may be connected with an individual's defensive need to obscure his meaning. Disjointed speech may occur because the person is more interested in playing with word sounds than communicating, or may be more interested in *not* being understood than being comprehensible. However, another mechanism may be at work.

Mr. Tilden had some thoughts about his brothers the day before. He wanted to discuss them in his session, but wasn't sure it was a good idea. He said, "I'm afraid the idea will become cold and hard like a fossil." Later on, he said even more obscurely, "When I talk about it (the subject of his brothers), I feel like I'm plugging myself up."

On the surface, these utterances might appear to be "looseness of association" or a variant. They might seem to result from a disturbance of the "synthetic function" of the ego (Nunberg, 1931). However, after some enquiry, Mr. Tilden seemed to be verbalizing a private conception, albeit in an imperfectly conceptual and public way. He felt, as many psychotic patients do, that he had been coerced by his parents who did not care to understand his real self. His mother had

appeared sympathetic, and he had let her into his emotional life, only to find that she consistently had her own agenda and needed him to fulfil her own needs. By means of her explosive temper, his mother had made him feel "splintered". Unless his behaviour conformed with her image of him, he felt, he could be exposed to an intimidating and self-shrinking barrage.

As Mr. Tilden and his therapist discussed these details, he referred to a "plugged-up Steven" and a "secure Steven". The "plugged-up Steven" corresponded to his experience of coercion, which made him feel humiliated and angry. The "secure Steven" was a compliant, passive, hedonistic, lazy but seemingly content "false self", disconnected from needs for recognition, dignity, authority and initiative. Mr. Tilden was finally able to explain that if he were to force himself to talk about the idea he had over the weekend, it would only feel stale and irrelevant; dead "like a fossil". He would be coercing himself and treating himself as his parents had—"plugging" himself up, metaphorically speaking.

Mr. Tilden was presenting a private conception in his speech, and had not taken pains to translate it into a public concept. In his case, the capacity for conceptual thought was intact, and conventional verbal concepts were available to him. He was able, when asked, to translate his conceptional images rather easily into conventional language.

For psychotic people whose conceptual process has become concretized or perceptualized, standard, verbal concepts may not be so available. For them, concrete imagery and perceptions keep autistic conceptions prominent in their mental life. Sometimes this may be intentional for defensive reasons. Sometimes, however, the process may take its own course, and the individual may be unable to escape a kind of private mental incarceration with few verbal concepts to unlock his autistic cell.

Curiously, people diagnosed with schizophrenia are not only excessively concrete in their thinking, but also, at times, seem to be overly abstract. This may be understood in terms of the delinking of words from their underlying referents (Freud, 1915). Instead of associating words predictably and reliably, with fixed and agreed-upon concepts and meanings, people with thought disorder seem to detach the verbal signifiers from the signified. Words become used in a kind of "acoustic play"; clang associations, neologisms and perseveration are examples.

A patient remarked, "The effectuation of the assistance of the dynamism is a constituent of private pursuit."

A number of writers have referred not only to the communication function inherent in language, but the obscuring function as well. Kasanin wrote, "We find that words, sentences, utterances frequently are a mask for something the speaker *does not wish to disclose*" (1944: 16, emphasis added). Burnham (1955) speaks of the wish for and fear of communication. Stern (1985) makes a similar point.

Ms. Williams spoke incomprehensibly in the community meeting. She ate napkins and entered into long, obscure speeches. Later, she told me that she spoke so bizarrely to cover up the fact that she was scared.

Primitive self-destructiveness

I have already referred several times to Stern's formulations concerning the intersubjective self. The experience of interpersonal communion can be one of intense and special joy. When attunements fail, however, a great sense of aloneness can develop, or a coercive interruption of "going on being".

We may extend this a little, and hypothesize that the child may arrive at a "paranoid" view of his experience. He may feel that the mother *wants* to tone down, diminish, control or even somehow annihilate his core sense of self. As always, he faces the choice between aloneness, false-self formation or protest. A more ominous choice is also available; that is, the choice of "identifying with the aggressor", and in the service of preserving some kind of "communion" with the patient, actively trying to eradicate his own self-experience. Since the sense of a core self consists of a variety of components (e.g. a sense of spatial and temporal coherence, a sense of affective coherence, a sense of perceptual coherence and a sense of coherence of agency, among others [Stern, 1985]), the "undoing" of a sense of self may involve any, or all, of these dimensions. What one might call "masochism in the service of communion" in the adult may take a variety of forms: self-destructive passivity, self-destructive affective storms, self-destructive drug-induced perceptual chaos or self-destructive physical injury. If the individual believes that the other desires his annihilation, he may conclude that only the most complete eradication of his sense of his own self will satisfy his intersubjective partner. He may fantasize that by eliminating his sense of self he has eliminated the offending element that has blocked communion with his loved one. He may believe, at least in fantasy, that he can return to a time before there was a sense of self, a time when he did not experience, as such, the agony generated by gross misattunement. Clearly, this process may motivate the dissolution of self-object boundaries, which contributes to the further development of psychotic structure. It may also be the basis of what some clinicians thought to be a "death instinct".

Hallucinations and creative image formation

We may wonder whether the hallucinations we see in psychosis result from an image-making potential that has gone awry. One of the singular differences between animal and human mental life, we presume, is the capacity of human beings to "re-produce" visual and acoustic images in the service of thought. We "re-present" sights and sounds that are no longer present and use them as raw material for thinking. This extends the power and scope of our mental lives immeasurably. But it also may represent the "Achilles heel" of our mental life. When we can no longer distinguish between the images we create to think and the perceptions that come from the external world, a core component of our reality testing has broken down. When we become confused about what the difference is between our mental inventions and what is given by external reality, we stray into psychosis.

Man's capacity for imagination, distinct from perception, became crucial to our biological survival (e.g. toolmaking, culture), but it has removed us from the more concrete and probably more stable stimulus-response adaptation of animals. Animals (most animals at any rate) are prewired to fit their environments. They do not ruminate like Hamlet about whether to fight or flee. Man's unique adaptation, his capacity to think in images, is vastly more powerful, but also vastly more fragile and vulnerable to breakdown. Our thinking is not part of a prewired reflex. We are obliged to initiate it actively. And because it is set in motion by our own agency, we are free to use it for purposes of realistic adaptation, or for personal satisfaction (fantasy) or defence. When our thinking function is stretched too far in serving our psychological needs (or when it is for some reason biologically vulnerable), psychosis may be the price we pay.

An outline of disturbed reality testing

I would like to offer a summary of the way in which deconceptualization, perceptualization, the disturbance in the sense of boundary and disturbed language use undermine the functions of reality testing. I will refer to three of the essential components of reality testing I have described: the capacity to discriminate internal from external sources of perception; the capacity to discriminate self from object; and the capacity to empathize with the social criteria of reality.

The discrimination between internal and external sources of perception

1. Thought is sensationalized and perceptualized.
2. Since perceptions replace concepts, the distinction between perceptions arising externally and perceptions arising internally is undermined.
3. The "feeling" of reality may be attached to perceptualizations and add to the sense of their being real.
4. The absence of an inner realm of concept makes it more difficult to refer the perceptualizations back to their original *mental* source since the world of ideas and meanings no longer exists. These perceptualizations appear to have an obvious, tangible, empiric quality to them. There is no other way of accounting for them—other than that they, in fact, come from the external world—since they are no longer experienced as *subjective* mental phenomena.
5. Concepts that are sensationalized rather than perceptualized can become a source of hypochondriacal experience.

Self-object discrimination

1. The sense of boundary, which is normally flexible and somewhat permeable, becomes disturbed.

2. This disturbance arises because the individual's sense of self is influenced by the actions of the other.
3. This influence is experienced as an impingement.
4. This painful experience leads to a sense of vulnerability to the coercive effect of the other.
5. In itself, this disturbance in the sense of boundary does not constitute a blurring of the boundary between self and other.
6. Only when it is represented in deconceptualized or perceptualized form is it experienced subjectively as a dedifferentiation, or a loss of the sense of boundary.
7. The loss of boundary may be accelerated by a psychodynamic motive. The individual may wish to eradicate his sense of self to affect an intersubjective communion with a destructive other (masochism in the service of communion).

The social criteria of reality

1. The psychotic person has experienced a collapse of his inner, conceptual world.
2. This means a loss of verbal concepts that link him to the broader, common culture.
3. Thereby, he loses contact with social meanings and points of view.
4. As a result, he is not able to view himself objectively as an average social observer would.
5. This disturbance is compounded by the fact that his sense of a coherent self has been disrupted. Because of this, he has lost touch with, or has never known, what an average coherent self would feel like.
6. The individual thus experiences a bewildering world of social ritual that is opaque to his understanding.
7. His appreciation of the social criteria of reality is, thereby, impaired.

Notes

1 In this discussion, "perceptualizing" refers to a process by which sensory receptors oriented toward the *external* world (usually distance receptors) generate images. Spitz (1965) terms these sensations "diacritic". "Sensationalizing" refers to the generating of images associated with *internal* somatic impressions, such as hunger or proprioception. Spitz calls these "coenesthetic" sensations.

2 Spitz (1965: 56) compares the experience of formerly blind patients after cataract surgery to what he infers to be the infant's experience early on. At first, such newly sighted patients saw vague and blurry visual forms, but could not distinguish shapes, much less recognize objects. He quotes a report about one such patient: "She saw but it did not mean anything. She was not even positive that these new sensations were coming through her eyes." According to one patient, "everything appeared dull, confused and in motion".

3 Vygotsky (1934) calls this "bracketing".

4 For Piaget (Piaget and Inhelder, 1969), all such images are the result of an *active* sensorimotor process. Stern (1985) holds that such experiences are registered and form the basis of recognition memory. These memories are not necessarily the result of an active process, and thus one cannot speak of the infant fantasizing at this point. Accordingly, one cannot speak of the infant being capable of fantasy distortion. Stern argues from this that the infant's perception of his environment is essentially a realistic one, and that distortions of it enter at a much later, verbal stage.

5 For Stern, the distinction between recognition memory and reproductive memory is not so clear-cut. Some form of reproductive memory—"cued" memories—may occur very early on, considerably before eighteen months. In Stern's account, however, such memories do not seem to be the product of sensorimotor action so much as in Piaget's formulation. As a result, they are not subject so much to distortion based on wishes or other factors.

6 Red objects may be classed together on the basis of the red appearance of each, but the child does not have an abstract category for the *concept* "redness" apart from specific and concrete red objects that he sees.

7 It is evident that most human thinking tends most to lean on or recruit visual and acoustic images for its functioning. We preferentially use visual and acoustic images to stand for names and class concepts. Is there a reason why this should be so? Why, for example, should we not "think" in tactile, proprioceptive, olfactory or taste images? Spitz's formulation concerning diacritic and coenesthetic sensation suggests an answer. Diacritic sensations tend to be more precise and focal, and may be better suited to "stand for" or symbolize specific objects or ideas in thought. Effective social communication depends upon precise and delimited concepts, and it may be that the fact that diacritic sensations (e.g. visual images, acoustic images) are focal makes them more serviceable to represent specific ideas. Moreover, diacritic images arise from *distance* receptors rather than *proximal* receptors and this may have adaptive consequences for the testing of reality. Generally, sensations arising from the body are more urgent than those arising externally. These are the sensations that signal imperative and peremptory biological need. They are not only more likely to disrupt cognitive functioning than visual or acoustic signals, but it is in the interest of biological adaptation that they are not confused with auto-generated perceptions used for thinking. Certainly, if visual and acoustic signals used for thought are confused with perception, an individual's functioning would be profoundly impaired, and his reality testing compromised. But, in terms of the development of the species, it may be better to confuse auto-generated thought images with visual and acoustic percepts than with sensations related to hunger, breathing, sexual satiation or elimination. It may be for these reasons that, in evolutionary terms, we do not think with our gastric or tactile sensations, but rather with our visual and acoustic ones. To put it another way, we do not think with our stomach and skin; we think with our eyes and ears.

8 Certainly, it may be the case that there are neuroanatomic and neurophysiologic lesions that underlie the "slippage" from concept use to perception. But even if genetic, anatomic and neurophysiologic factors are implicated in this process, they may not generate these phenomena directly. They may act anywhere along the anatomic-physiologic-affective-cognitive network. Some individuals may be predisposed to such "slippage" from concept to percept, but actualize this potential only under conditions of severe stress. Some individuals may have a predisposition for attaching the "feeling of reality" (Frosch, 1964) (see Chapter 1 on reality testing) to their perceptualizations, resulting in frank hallucinations rather than seeing an image in the "mind's eye".

The relationship between biological and psychological factors in these processes is of compelling interest, but, obviously, extremely complex and not yet well understood.

9 Clearly, these integrative activities require motivation, and the patient, even if capable, may not want to re-experience affects and meanings that are painful. This process must be accompanied by a focus upon the patient's dynamic reasons for remaining isolated and out of touch. It is difficult to discuss the patient's emotions without a reliable language, however, and it is in order to develop a shared conceptual language that naming, enlargement and disclosure are used. These techniques are designed to help the patient reconnect with the social, conceptual world.

10 See the discussion of the pitfalls of premature "depth interpretation" in Chapter 3.

11 For another way of understanding Mr. Tilden's need to control his therapist's behaviour, see Chapter 5. I do not think that these two views are necessarily at odds.

12 It may be that for such patients, the connection to the object is not what might be called "discretionary". The loss of the other does not result in sadness, which can be tolerated and absorbed, but rather is experienced as unbearable and globally threatening to the self. This may be because, developmentally, threats of loss occurred at a time when, in fact, the mother *was* indispensable, as a need-gratifying object (Freud, 1962), for physiologic regulation or to satisfy an imperative need for interpersonal affectivity and intersubjectivity (Stern, 1985). In any event, the presence of the object may not feel discretionary.

13 Weisman (1958) calls this the "sense of reality".

14 Klein (1935) referred to the "denial of internal reality". Jacobson (1964a) also referred to this phenomenon.

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7

OUTCOME

Reporting the results of the psychotherapy of the patients described in this book is problematic for several reasons. The number of patients involved is small. One must be cautious about generalizing findings from such a limited group. Clinical presentations and responses to interventions may be skewed because of the small sample size. In addition, the format of the study is clinical and anecdotal. Because of the limited sample size, and because of the technical difficulties of doing psychotherapy research, the outcomes described here focus on individual case material. Such material cannot furnish "proof" of a clinical or theoretical hypothesis, and can only illustrate and provide clinical observations. It remains for the reader to determine whether this data is convincing and useful.

Two broad categories of outcome can be described. The first concerns what I have called the "fundamental practical goal", which consists of helping patients put their thoughts and feelings into words. Verbal psychotherapy of whatever kind cannot occur without such a capacity, and for many patients diagnosed with schizophrenia, this function is disturbed at the outset. The traditional techniques of psychotherapy (i.e. clarification, confrontation and interpretation) cannot function unless the patient is able to communicate a coherent emotional theme to the therapist. If the patient's acting out disrupts the therapeutic setting, or if his use of verbal symbols is disordered, the therapist cannot understand him. Often the therapist must work actively to help create what we take for granted in working with neurotic patients: a setting in which the patient is able to use coherent speech to communicate his inner states. Accomplishing this vital task leads to greater conceptualization and socialization of thought, and to the development of insight.

The other kind of outcome concerns changes in the quality of the patient's life: changes in his object relations, his integration of aggression, his capacity to tolerate affects such as emptiness, despair, envy, loneliness, sadness and longing for contact. Success in this area involves a reduction of emotional and interpersonal withdrawal. It also involves a reduction of the patient's denial used to block out external reality (especially his awareness of the interpersonal aspects of reality) as well as his internal feeling states. Such changes strengthen the patient's ability to appreciate the social criteria of reality, and thus reality testing in general.

Increased capacity to use words and concepts

As noted in Chapter 4, the use of naming and enlargement helped many patients to increase their capacity to put their feelings and thoughts into words. Insofar as these patients had deconceptualized their thinking by means of perceptualization or sensationalization, or had translated concepts into action rather than ideas or affects, this seemed to lead to at least some reconstitution of conceptual thought.

Some patients recovered concepts and affects that appeared to be "hidden" in somatic sensations.

Mr. DeVito, who had experienced a painful sensation in his throat, was eventually able to connect it with the affect of loneliness. Similarly, he was able to understand that the sensation of having "a hollow in (his) abdomen" was associated with the feeling of emptiness. Later, he was able to elaborate further, describing his inner state as being like "a barren chasm where no human comes in" and like "a deep cave with colourless walls".

At the beginning of psychotherapy, Ms. Weiss literally felt that her mind had calcified. She experienced this as a sensation, and believed that something was wrong with her neurologically (an extensive neurologic workup was negative). Gradually, she was able to connect this sensation with the inner realm of thought and feeling in which she felt emotionally hardened, dead and empty.

Some patients came to recognize ideas and affect that had previously been perceptualized.

Ms. Bender had experienced Dr. M being intrusive and grating in the form of a visual image of an abrasive scouring pad. She was finally able to connect that visual image with her emotional experience.

Ms. Chen was able to link the perception that her therapist was using tweezers to pinch her ear with the emotional experience of being hurt and controlled. Eventually, this extremely guarded and concrete woman was able to reveal a more vulnerable and emotional side when she described herself as a desolate and fruitless orchard.

Other patients began to understand the link between symptomatic actions and their emotional states.

Before one hospitalization, Mr. Martin had lit a massive fire in his fireplace during the summer because he felt his relatives had given him the "cold shoulder". Eventually, he was able to describe the frigidness of the emotional climate in his family.

Ms. Williams had entered the hospital talking gibberish and was later able to acknowledge that this protected her against her feelings of vulnerability and shame.

Mr. Tilden was able to recognize that his manner of thinking and speaking in private (rather than publicly shared) phrases served to protect him from rejection and pain.

Ms. Williams' propensity for action, especially for getting into fights, gradually diminished as her capacity to identify her inner life developed. This initially

impulsive and inarticulate woman was eventually able to say, "I don't feel human when I'm all alone. It's like an immense expanse of nothingness."

It appears that the reversing of deconceptualization leads to a resocialization of thinking. Thinking emerges from a private conceptional world and once again is connected to the public, shared world of class concepts. The patient can begin to use culturally shared concepts and can more easily link himself to the inner lives of others.

Mr. Tilden used a private language in which "couch", "fireplace", "sunny" and "music" meant "soothing". He felt that his ideas wandered around as if they had lost their way and were no longer connected to the outside world. He and his therapist were eventually able to discuss ways in which such private conceptions and "half-thoughts" helped Mr. Tilden protect himself from the fear of relating to others.

Ms. Williams also used private thinking and speech to create a protective wall between herself and others. "The statements I make," she said, "are so that people won't know what I'm feeling."

Ms. Hunt used rapid speech filled with private allusions to avoid contact with others.

In these cases, what appeared phenomenologically to be profound looseness of association proved to be at least somewhat remediable. The patients learned to use public concepts rather than private images and became far more comprehensible.

Once the patient has access to shared cultural symbols (i.e. class concepts), a "calculus" of conceptual thinking can develop. On the simplest level, one concept can be associatively linked to another. These links are no longer established on the basis of physical or temporal contiguity, or perceptual or sensory similarity. Links based on such contiguities are the basis of primary process and concrete thinking (Freud, 1900) and what Vygotsky (1934) referred to as thinking in congeries, complexes or pseudo-concepts. In truly conceptual thinking, links are established on the basis of a similarity in the form of *concepts*, rather than of concrete sensory images. It seems that these kinds of links spontaneously lead to the formation of analogy and metaphor.[1]

In symbolic logic (Langer, 1967), analogy refers to a similarity of *form* between two phenomena. One form may be used to stand for or symbolize another. *Metaphor* is a closely related linguistic structure. Metaphor points to an analogy between two forms from different frames of reference (technically, different "universes of discourse"). When a poet compares his lover's sparkling eyes to twinkling stars, he is equating two similar forms (radiance) from different frames of reference. Metaphor expands our cognitive lexicon by asking us to look beyond conventional associations and to see new meanings highlighted by a new frame of reference (Ricoeur, 1976). The poet realizes, for example, that, like stars, his lover's eyes seem ethereal, magical and brilliant.

It appears that once abstract class concepts have been generated, the linking of such class concept elements via analogy and metaphor becomes much easier, and, at times, seems to proceed spontaneously.[2] This expands the realm of conceptual

rather than concrete thought. It also allows a deeper experience and expression of emotions and emotional connection to others.

When Dr. C missed an appointment due to an illness, Ms. Williams, the formerly inarticulate twenty-year-old, said, "Well, I felt like you deserted me. Like you deserted the ship." Her metaphor of the ship implied a camaraderie with a crew and a trip with a destination, suggesting the existence of an alliance as well as hopefulness despite her disappointment. In discussing her feelings, she commented: "Missing people is like a wound, not a physical wound, but a mental wound."

Mr. DeVito described his sense of isolation and longing for others. It was, he said, "like being in a glass jar, and being unable to get out". In describing his sense of loss and the feeling that he had no value, he said: "It was as if I dropped a hundred diamonds from a cliff, and watched them vanish into the sea." In portraying his tendency to withdraw into silence during conversations, he said, "Silences are like a dungeon in which I stay cut off from others."

Ms. Williams commented on her missing a friend who was being discharged from the hospital, "I feel like my heart is being ripped out of me."

This somatic metaphor seems to border on frank sensationalization of thought. One can easily imagine that such a metaphor might become the basis of a deconceptualized somatic sensation of heart pain. At this point, Ms. Williams was more able to tolerate her affect states, and she was explicitly drawing a comparison between pain in the heart and pain in the sphere of her emotions. The pain in her emotional universe was no longer sensationalized as sensory pain.[3]

The metaphors described above represent thinking that has emerged from concreteness associated with the diagnosis of schizophrenia. These statements explicitly acknowledge an inner psychic life that can be described by comparing it with analogous physical phenomena. However, the distinction between the psychic and the physical is preserved. Physical reality serves as an analogy to mental and emotional life; it is not an equivalent.

The spontaneous development of insight is closely connected with the development of analogy and metaphor. According to symbolic logic (Langer, 1967), insight is considered to be an intuitive capacity to see equivalent forms in different phenomena.[4] In psychology, insight might be described as the capacity to recognize equivalent forms in psychological, emotional or behavioural life. As with analogy and metaphor, once class concepts are more available, the process of comparing them, contrasting them and organizing them more readily appears. All the patients discussed in this book spontaneously began to make such cognitive links and to attach meaning to these comparisons.

Ms. Williams talked about missing her friends in the hospital, and how lonely she would feel when she left. She recognized a similar "emotional form" in her past. She said with genuine surprise, "You know, this is why I used crack on the outside. I felt lonely and like I had no one to talk to. Like when my uncle died. I felt terrible. It was awful. We went to the wake." Later, she added, "I think this is why I used crack. I think it was to get away from my feelings." Still later, in discussing

a relative who had emigrated to Mexico, she said, "I feel really bad. This is what caused me to smoke crack. Feeling like this is how come I used (drugs)."

The evolution of analogy, metaphor and psychological insight described above seems to reverse the regressive path I hypothesized (see Chapter 6) from concept to perception and sensation that underlies hallucinations and concrete thinking. Patients who begin by experiencing uncanny perceptions and sensations appear to progress by means of naming and enlargement to the use of class concepts and, finally, analogy and metaphor. It is only at this point that insight, as defined above, is possible, and this can emerge spontaneously. Concepts, the building blocks of insight, are generated at first by the capacity to name. It is the development of this capacity that is the "fundamental practical goal" of psychotherapy with patients diagnosed with schizophrenia, and that the techniques described in this book most immediately aim to achieve.

Revealing painful affects

Once patients developed a willingness and capacity to put their inner experience into words, they were able to reveal certain characteristic painful emotions.

Revealing feelings of emptiness, deadness and rage

Most of the patients described in this book experienced a painful sense of inner deadness and emptiness. We recall that Mr. DeVito described himself as a barren chasm and Ms. Weiss felt that her mind had calcified. Ms. Williams reported feeling a "vast, empty void" within her. Ms. Jackson and Ms. Chen suffered from a similar feeling of hollowness. The feeling of emptiness and the associated experience of deadness was a very characteristic feature of the inner lives of these patients.

Nancy Morgan was a twenty-five-year-old woman with a history of auditory hallucinations, paranoid ideas, grandiose delusions and social isolation. There was no prominent history of affective symptoms. She had been preoccupied since her early teens, when she first became ill, with concrete concerns about medication issues; for example, when to take her pills and what dose to take. After about six months of psychotherapy, she was able to put her feelings of despair into words, feelings she had previously pushed out of her awareness. She wept and said, "Nothing will make any difference. I'll never be like other people. I'll never get married, I'll never have children. I'll never do anything useful. There's nothing inside that anyone would ever want to get to know or love. I'll always be alone."

One of the most difficult aspects of psychotherapy for these patients is the effort to put feelings of despair into words. A great deal of suffering and hopelessness is connected with the experience of emptiness and deadness. Many of these patients would much prefer to hallucinate, hold onto delusions or behave bizarrely than to confront the loss of self-feeling. The focus of much of the psychotherapy

is to help the patient "stop, look, and listen" (Semrad et al., 1952; Semrad, 1966) and turn conscious attention to these feeling states.

Interestingly, there appeared to be a rather strong connection between these experiences and a powerful rage that was split off and denied. When the psychotherapy was able to help the patient feel more conscious anger and destructiveness, the patient often felt more alive, more vigorous and more real.

For many years, Mr. DeVito had felt isolated, dead, inert and formless. He felt little inner vitality, purpose or initiative. Gradually, he began to feel more able to express his annoyance and, finally, rage at his cousin, whom he felt had always been disrespectful. This culminated in a yelling match at a local bar. He was also able at this time to become angrier with Dr. B and expressed the wish to smash Dr. B with his fists. He had a dream of murdering a man who appeared to be a thinly disguised version of his therapist. The expression of these feelings was frightening, but also seemed quite liberating. Mr. DeVito's sense of deadness began, slowly, to lift. "I feel like I'm having my natural feelings now. I didn't put the brakes on with my cousin. I feel like I'm a real person." For the first time, he said, he felt like he had a centre and was not so unclear about what his feelings were. He did not feel so confused about what to say in social situations.

Ms. Weiss talked about a long-standing feeling of inner lifelessness. Virtually nothing could change it. Therapy sessions were filled with a sense of torpor, apathy and nothingness. Dr. E suggested that her inner lifelessness might be a way of shutting herself down so that she could not harm anyone with her rage. Usually, this interpretation did not produce much change. Rather suddenly, Ms. Weiss began to talk about violent and murderous wishes. She wanted to blow up the state capitol and kill the governor. She felt out of control and was worried that she might want to hurt Dr. E. During this time, Ms. Weiss seemed more animated, more activated and more alive, even though tense and extremely frightened about her "raving" and being "on a rampage". As quickly as they had come, her fantasies of murder and violence vanished. Once again, she returned to her customary torpor. It seemed to her therapist that she had disarmed herself by dismantling her executive apparatus. In such a state she could not blow up buildings, and could not harm anyone.

Unlike neurotic patients whose inhibitions about aggression occur only in limited areas of conflict, Ms. Weiss' defences were much more far reaching. In effect, the entire ego apparatus was put out of action. Ms. Weiss hinted at such a mechanism when she said at one point, "My mind doesn't work well enough for me to get mad." In a similar vein, Mr. Tilden commented, "There are pressures in my mind that block me from thinking."

Revealing the feeling of a damaged or destroyed self

Most of the patients described in this book experienced either an extremely fragile or a nonexistent sense of self. The more patients became able to report their inner states, the more they were able to reveal a disturbance in their sense of self.

Mr. DeVito complained bitterly of an "absence of self" and felt that he had nothing to say in conversations because there was no centre to his personality.

Ms. Chen often felt "fractured" and that her body was vulnerable to manipulation and attack.

Mr. Tilden also felt "splintered" by contact with others, and felt extremely vulnerable being intruded upon and controlled.

Frequently, patients reported that they needed to maintain a secret and protected place where the self could exist safe from criticism, intrusion, coercion or attack. Mr. Tilden said that he sometimes felt like "a turtle" who "hid under his shell" from people who could "splinter" him. Ms. Chen spoke of a "personal space". When people intruded, she felt like exploding with anger. These reports are reminiscent of Winnicott's (1960) formulation concerning the defensive function of a false self that protects the true self that has been secreted away.

Mr. DeVito discussed his fragmentary sense of personal identity and said that perhaps he avoided a more definite knowledge of his feelings and thus a more definite identity to escape retaliation for his destructiveness. Mr. Tilden revealed that he was afraid to assume a more specific identity because he felt it would be too confining. He said, "I can't decide what job to take. If I picked one, and didn't pick another, I would feel like I was being drowned or smothered. It would be like being locked in a closet." Searles (1979) reported something similar in the psychotic patients he worked with. He believed that some of his patients were afraid to consolidate their sense of identity for fear that they would be confined or suffocated by the limits of any self-definition they might adopt.

Some patients feel that psychotherapy entices them to "come out" of a fantasy or dream world and prods them to enter the harsher, colder "real" world. This can feel enormously unsafe and threatening. Patients may feel discouraged, painfully lonely and bewildered by all the demands of everyday life. They may feel sapped of all their energy, as if unplugged from a source of security and animation in the world of fantasy. Mr. Tilden "came out of (his) cocoon" only to feel a debilitating lassitude. He said, "No one cares, no one calls. There was nothing for me in my cocoon, and there is nothing for me out here." He went on, "Being optimistic in my fantasy cocoon was easy. Being optimistic in the real world is not."

Mr. DeVito expressed similar feelings about going out into the world. He had several dreams that linked living apart from his relatives with the possibility of sexual relations with women, and exciting adventures. Nevertheless, each time he tried to live separately, his sense of loneliness in a world utterly indifferent to his presence felt intolerable. To escape these painful feelings, he spent much of the day sleeping.

Decreased denial

As I noted in Chapter 2, many writers believe that the denial of external and internal reality is a building block of psychotic structure. Denial of external perceptions, of social conventions about what is real and of inner affective states plays

a large role in psychotic functioning. In the realm of the internal world, denial wards off excruciating affects such as emptiness, deadness and a sense of being inhuman or monstrous, as well as loss. In the realm of the external world, denial wards off perceptions and impressions, which are linked to meanings that can generate intolerable emotions.

Perhaps with the exception of paranoid reactions, denial is the psychological phenomenon most resistant to change in psychotherapy. It leads to a massive and far-reaching change in the balance of mental forces. When external reality and internal affect can be escaped, all kinds of psychotic anxiety-reducing psychological adaptations become possible.

Denial is primarily directed against the experience of painful affect. The techniques described in this book, aimed at helping people experience their emotions, seem to have helped at least some of the patients to reduce their use of denial. Some examples of greater recognition and sharing of painful feelings have already been given. I will describe another.

Mr. Tilden had not worked in months. He spent a lot of time thinking about his future and what kind of career he wanted. He wondered if he should become a musician. Similarly, he wondered if he should become an actor. He put great stock in these possibilities, despite having no experience or training in either. These options seemed disconnected from any material evidence of talent or commitment. At the same time, he angrily rejected jobs that he considered beneath him. It is characteristic of some people diagnosed with schizophrenia that they reject undemanding work, which they consider too simple and demeaning, but tenaciously hold onto plans for careers requiring talents and abilities, which there is little evidence they have.

Mr. Douglas, a twenty-five-year-old man diagnosed with schizophrenia, had completed two years of college, but he had not been able to keep a job. He said maybe he would pursue a career as a sports broadcaster. Maybe he would take classes in the spring. He asked if he should pursue a career in radio announcing. After some discussion, his therapist said, "I don't quite understand why you would plan a career as a sportscaster, when you have not done any work in radio. You have not taken any classes, and have not had an apprenticeship." Mr. Douglas became furious. The therapist only wanted to crush his dreams and make him feel worthless. After more discussion of feelings of embarrassment, hurt and sadness, he was able to acknowledge how painful it was to feel he was less skilled and talented than others, and that while he might have talent as an announcer, nothing he had done so far would lead an employer to hire him.

In work with psychotic patients, one sometimes comes to a point where it seems that a crossroads is reached. Split-off delusional beliefs collide with an increasingly competent and adaptive ego. Such a moment can have a curious, topsy-turvy quality where the figure and ground of psychosis and health wrestle for supremacy. The psychotherapy of Mr. DeVito provides an example.

Mr. DeVito had been hospitalized twice in quick succession. It was not clear exactly what had precipitated these hospitalizations. One factor seemed to be his

paranoid fears of returning, after his first hospital stay, to the neighbourhood where he lived. Another appeared to be his recent unsuccessful attempt to live in an apartment apart from his aunt. This failure had left him feeling lonely and shaky.

For some time Dr. B, his therapist, had emphasized how important it was for Mr. DeVito to be able to function at work. This had a certain sense to it in that when he wasn't working, Mr. DeVito became more and more withdrawn. At such times he stopped functioning as an adult, and became a kind of "lump". Self-esteem based on his real-world achievements, of which there were several, seemed to fade into oblivion, and could not help support his efforts to assert himself and succeed. Work had always seemed to be an island of healthy adaptation that anchored him in the real rather than the regressive, interior world.

Despite Dr. B's encouragement to return to his bank job (which he had worked at with success for five years), Mr. DeVito decompensated repeatedly. He became paranoid and delusional and was holed up in his room. He insisted during these episodes that he was not crazy and that he was simply "taking a rest". On another occasion he took a ferry to an island off the Oregon coast where he barely survived—he was discovered and rescued by a park ranger. He insisted that this had nothing to do with being ill, but was, instead, a "voyage of self-discovery". He said, "I don't want anyone calling me sick. I am not sick. There is no way I'm sick."

After his second hospitalization, Mr. DeVito raised the issue of insurance coverage with Dr. B. He asked Dr. B to talk with the medical benefits officer at his bank so that he could be reimbursed for his hospital stay. Dr. B pointed out the contradiction in what Mr. DeVito was doing. On one hand, he insisted that his locking himself in his room and his trip to the Oregon island were not a result of illness and insisted that he was not sick. On the other, he wanted medical experts (including Dr. B) to certify that he was entitled to benefits because of illness. Mr. DeVito gave an unguarded laugh and said, "I'm in a tough spot, I guess. I really got myself in a jam. I need the money. I'll have to think this one over." Over time, he began to think more seriously about his "illness". To acknowledge his illness for him was to acknowledge that he was "crazy". When he was finally able to consider this possibility seriously, he wept inconsolably.

The deepening of intimacy and relationships

Many of the patients who participated in psychotherapy for an extended period of time became more deeply involved in human relationships. They were more able to seek contact, to ask for help, to acknowledge the importance of others, to tolerate delay and frustration, to take risks and to reveal themselves to others. By and large, they were better able to avoid the temptation to break off relationships when loss and pain felt overwhelming.

Ms. Williams had worked with Dr. C for many months in the hospital. When Dr. C told her that she would be leaving, Ms. Williams responded by avoiding several meetings. Finally, she came and talked. Despite her sense of betrayal,

pain and anger, she was committed enough to her relationship with Dr. C to tell her how she had hurt her. She said, "I feel like you are walking out on me. Like everyone does." Later on she exclaimed, "To hell with you. I wish you were a can I could crush." A short time later, Ms. Williams told Dr. C, "When you go (from the unit), I'll feel alone and sad. They'll want to give me a new therapist. But it won't be the same. I don't want someone different. I just want to work with you."

What was impressive was that for most of her life, Ms. Williams had translated painful affect almost immediately into action. She had distracted herself with cocaine and affected the pose of a devil-may-care gang member. During the later stages of her hospital treatment, she was able to tolerate sadness and loss, and to put those affects into words. Moreover, she was able to acknowledge that Dr. C was someone important to her, who could not be summarily replaced. All this was accompanied by great inner pain.

Mr. Tilden often appeared to pursue his own thoughts. He got caught up in elaborate fantasies and disconnected ruminating. He expressed great scorn for his therapist, Dr. T. When Dr. T asked about this, he became enraged. He insisted on changing the subject. Nevertheless, Dr. T persisted, and Mr. Tilden experienced her as attacking and controlling, in an effort to destroy him. He felt accused of being a sinister person. Finally he wept, and said that it was true, he did have a destructive side. He also acknowledged that he needed the therapist to support him and help calm him, and that to admit this made him feel frightened, vulnerable and exposed.

Mr. Tilden was able to tolerate frustration, suspiciousness, fear of attack and pain well enough to refrain from discarding his therapist as an enemy. He was able to acknowledge unpleasant feelings, and to maintain an image of Dr. T as someone who was at least somewhat valuable. Mr. Tilden's temptation to dismiss Dr. T in a paranoid rage was great.

Along with an increase in these patients' capacities to establish a relationship with the therapist came improved interpersonal functioning in their lives outside therapy.

Mr. Tilden developed a number of friendships that helped him feel less isolated and alone for the first time in his life. Also for the first time, he began to have some sexual contact with women. After years of difficulty concentrating and functioning at work, he was able to perform well at a job, which required considerable interpersonal skills, over a period of several years.

Ms. Chen, who had been a virtual isolate since childhood, was able to develop a romantic relationship with a man that lasted almost a year.

While this relationship stirred up intense emotions that ultimately led to its breakup, still Ms. Chen's willingness and ability to endure the ups and downs of intimacy was a genuine step forward. Ms. Chen, who felt that the preservation of her "personal space" was a matter of survival, had been able to spend long weekends with her boyfriend during their relationship. Before the end of therapy, she had weathered several rifts and reconciliations with her boyfriend and gained real experience in being intimate.

Ms. Williams became aware of a need for other people that seemed not to have existed before. When she first began psychotherapy, she was physically intimidating and bizarre. She had little contact with her own emotional life, and was not aware of the impact of her actions on others. Her peers on the unit kept their distance. When her psychotherapy ended, she was able to feel sadness, loneliness and affection in much greater depth. Moreover, her fellow patients sought her out to include her in their lives. This meant a great deal to a woman who had felt herself to be a kind of excommunicated monster.

Mr. DeVito had lived with his aunt and uncle for a year, and had not had a relationship with a woman since college. Over the course of his psychotherapy, he was able to maintain several friendships with his male friends, and establish significant relationships with several woman. He dated one woman for several years who ultimately wanted to marry him. The relationship broke up, perhaps because Mr. DeVito was frightened of this degree of intimacy. Still, Mr. DeVito had allowed himself to make a powerful bond with someone outside his family for the first time in almost fifteen years. Despite the breakup of this romance, Mr. DeVito did not retreat to his former isolation, but after a time was willing to try relationships with other women.

Ms. Sanchez: an example of a successful psychotherapy

I would now like to discuss the treatment of a woman who benefitted enormously from psychotherapy. A portion of this material may repeat, although now with a different focus, what has been said about Ms. Sanchez in other chapters. This case presentation is highly condensed and only a sketch of the complex course of this patient's treatment.

Ms. Claudia Sanchez suffered from profound psychiatric symptoms and from the social isolation and hopelessness that resulted from them. She started out in life as a bright, accomplished young teenager, and then in her junior year of high school became increasingly psychotic. After a number of lengthy hospitalizations, she grew progressively more despondent and isolated. Eventually, she wound up living by herself in a women's shelter. Despite her suffering, she was able to make contact with a psychotherapist during one of her hospital stays. I will describe the course of her psychotherapy and the changes she was able to make.

Ms. Sanchez grew up in California and did very well academically, graduating from the University of California, Berkeley. She had a number of good friendships and dated several young men. Her first hospitalization occurred at the age of seventeen following a depressive episode. Two years later she was hospitalized again, this time with psychomotor agitation. She was diagnosed at that point with bipolar II disorder. After college, Ms. Sanchez became frankly psychotic with auditory and visual hallucinations, paranoid delusions, disorganized speech and ideas of reference. She had multiple somatic hallucinations including the sensation that electric currents were running through her legs and that her body was not really solid. These psychotic experiences occurred in the absence of mood

symptoms. Ms. Sanchez was rediagnosed as suffering from schizophrenia and was treated extensively with a wide variety of first and second generation antipsychotics. She was also prescribed an array of mood stabilizers. None of these medications had a significant effect. Some members of Ms. Sanchez's family had been diagnosed with affective disorder, and some with schizophrenia.

Until her early twenties, none of her treatments included psychotherapy. During one hospital stay Ms. Sanchez worked with a young occupational therapist, Ms. O., who she felt was caring and supportive. Ms. Sanchez grew fond of Ms. O. Eventually, however, Ms. O was assigned to another inpatient unit, and Ms. Sanchez was devastated. Soon after, her psychotic symptoms became more severe. She heard a persecutory voice declaring that Ms. O was St. Teresa and that Ms. Sanchez was her disciple. According to Ms. Sanchez, Ms. O demanded that she obey her in every detail and required her to behave in self-defeating and socially embarrassing ways to demonstrate her loyalty.

During an extended hospitalization, Ms. Sanchez met a female psychologist, Dr. F. She began psychotherapy three times per week. They discussed the ways she felt enmeshed with her family. She felt that her mother and grandmother clung to her and depended on her for a feeling of purpose in life. They seemed to have no existence outside their focus on her. Sometimes, she felt so trapped that she became enraged and had fantasies of strangling her grandmother with rope. She was horrified by these images, and panicked that without these over-close attachments she would not survive. Ms. Sanchez felt that her relationship with the voice of Ms. O was remarkably similar. Ms. O too was possessive and demanded that she remain devoted and attached. Ms. Sanchez felt powerless—she could neither bear feeling dominated by the voice nor could she imagine living without it. The relationship with the voice left Ms. Sanchez feeling that there was nothing to live for.

Ms. Sanchez's psychotherapy focused simultaneously on her relationship with the voice of Ms. O and her relationship with her family. Dr. F interpreted that Ms. Sanchez's rage might be frightening, and might lead her to feel impotent and weak to reassure herself that she was not powerful enough to cause harm to anyone. She commented, "To kill Ms. O would make you feel very guilty. So, it is you who becomes the victim (of your rage), not her. (This way) you don't have to have such a bad conscience." This session was followed by a dream. In this dream, Ms. Sanchez pictured herself as a deadly CIA agent. While on the one hand this frightened her, on the other she seemed to be covertly invigorated by this self-image. Ms. Sanchez then associated to thoughts of her parents and grandmother whose lives seemed so empty. Their unhappiness weighed so heavily on her. To have to give up her own dreams in life to keep them company seemed so unfair. An insight occurred to her spontaneously, and she declared to Dr. F: "Do you think my parents are like Ms. O? Do you think I want them to disappear (like Ms. O)? They have a hold on me. I'm supposed to serve them. Maybe I keep this image of Ms. O close to me, like I keep them close to me." Dr. F remarked that perhaps separating from her needy parents led Ms. Sanchez to feel she was abandoning them, or worse, killing them. It must make Ms. Sanchez feel very guilty, Dr. F supposed.

OUTCOME

Now an outpatient, Ms. Sanchez began to feel stronger. She was able to link her sense of obligation to her parents to her delusional belief that she was the servant of St. Teresa. Over time she was also able to see the connection between her own imperious anger towards her family and Ms. O's caustic, domineering voice. Dr. F suggested that Ms. Sanchez could only permit herself to be in touch with her rage by experiencing it as a victim, not a perpetrator. As Ms. Sanchez was able to bear and understand these feelings more deeply, she became more socially engaged, developing some friendships and even dating several men. The voice of Ms. O was not at all pleased with these developments and began a campaign of recriminations and threats. At first these had a haughty and condescending quality. How dare Ms. Sanchez defy her orders? it screamed. Over time, as Ms. Sanchez continued to free herself from its influence, the voice became more conciliatory, even pleading. It seemed as if the voice acted like a bully, finally confronted. Gradually, Ms. Sanchez's fear of her own aggressive power subsided, and her comfort in being assertive grew. She found a paying job as a clerk, and eventually signed up for computer training. After several years, she was able to get a degree as a certified public accountant and was hired by a well-respected firm. She dated several men and eventually settled into a committed and sustained relationship.

The relationship with the voice continued over a long period of time. Whenever Ms. Sanchez took a step forward in terms of her autonomy or social functioning, the voice would pounce, either haughtily scolding her or cravenly appealing to be taken care of. Over time, these "shenanigans" (Ms. Sanchez's term) became familiar to her and increasingly faded into irrelevance.

Of note, Ms. Sanchez emphasized that the malign effect of Ms. O on her life centred on the destruction of her ability to love. (See Chapter 9 on the shattered self.) Ms. O sewed doubt in Ms. Sanchez about her goodness and the value of her affection. Partly as a consequence, she had withdrawn from others, which left her feeling futile and that her life was pointless. Without a sense of the value of her love, her feeling of unity and coherence deteriorated. It also left her feeling that she had nothing to exchange with others in return for their care and kindness. Without the sense of meaning connected with feeling love, there seemed to be nothing to hold her "self" together, and she experienced herself to be in fragments, different body parts loosely and bizarrely organized. When Ms. Sanchez was able, once again, to make contact with others, especially when she was able to feel affection, her sense of self consolidated and she felt "real".

Ms. Sanchez continued in psychotherapy with Dr. F as an outpatient for many years. She was never hospitalized again and her hallucinations occurred only once every several months. When they did, she experienced them as alien curiosities that had to do with some emotional strain she was then experiencing. Her psychotherapy became a more standard one and focused on her emotional relationships with her friends and family and with stresses at work. She and Dr. F continued to work on her ability to feel and understand her emotions and develop her personal talents and ambitions.

Notes

1 One may speak of a primitive and concrete type of analogy, such as the infant's awareness of the similarity between the shape of a crescent moon and a banana. This kind of analogy is the basis for primitive unconscious symbols such as phallic symbols. It consists of a recognition of similarity in simple perceptual or sensory experience. In the above discussion, analogy refers to a similarity in the form of culturally shared class concepts. This involves a recognition of similarities between experienced distant or "abstract" concepts.
2 Certainly, without the building blocks of concepts, abstract conceptual thought is impossible. There are no concepts to organize or compare, there are no ideas to think "about". Thinking, even if it were potentially possible, would have no elements to act upon. According to Bion (1957), thinking evolves to deal with thoughts.
3 Certain emotions may actually be associated with certain physiologic states: emotional hurt or lonesomeness with pain in the heart, anxiety with dizziness, rage with a sensation of heat. When thought becomes concrete, the realm of affect collapses and becomes replaced entirely by the sensations that were previously only physiologic accompaniments.
4 Recognizing the similarity between a spiral staircase and the structure of DNA is, for example, an insight.

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8

PARANOIA

Clinical presentation and psychodynamics

The subject of paranoia is as complex as any in psychology and treatment is even more daunting than understanding. Paranoid experience can involve the most primitive and automatic self-preservative functions of the mind and brain, mobilizing all varieties of defence: withdrawal, self-protection, evasion and attack. Paranoid experience plays havoc with wishes to affiliate and transforms relationship-seeking into a terrifying danger rather than an experience of soothing and self-consolidation. Paranoid states can make it virtually impossible for an individual to experience any person or anyplace as "home"—an oasis where he can find rest and support. Instead, people experiencing paranoia hover, like a hummingbird, too afraid to land in any relationship for fear of attack or exploitation.

Paranoia usually involves a primitive way of coping with dangers—either physical or emotional. It involves a heightened sense of vigilance to surroundings, and a preparedness to withdraw, defend or attack potential threats. Paranoia, of course, is characterized by an inability to trust. The ability to trust is, in turn, a complex function involving multiple crucial capacities: the capacity to feel safe in being taken care of; the capacity to take risks in depending on another human agent; the capacity to bear disappointment or pain without excessive rage; the capacity to tolerate intense ambivalence and guilt generated by simultaneous love and hate; the capacity to recognize projections as originating in the self; the capacity to bear pain when one's love is not accepted; the capacity to tolerate losses in self-esteem; and the capacity to empathize with the mental experience of another self (to "mentalize".) Since these capacities are called upon in an almost endless variety of circumstances, the risk of paranoid reactions is ubiquitous. Some or all of these capacities may be impaired, to a greater or lesser extent, resulting in a very wide variety of possible paranoid experiences. These range from the slight suspicion that one's coworkers may be resentful after a promotion to the paralyzing fear that your closest friend is reading your mind to enslave you.

One of the problems with paranoid experience is that it poisons the possibility of comforting and sustaining object relations. Metaphorically speaking, if

one is suspicious of one's food, one does not eat. Nevertheless, one's hunger grows ever more intense. Since nutrition is necessary to survive, this avoidant defence is unsustainable and some kind of (usually aggressive) outcome is inevitable. In addition, paranoid experience is exhausting. One cannot do without human support indefinitely, and the urge to affiliate returns despite the paranoid patient's vow to remain separate and protected. As a result of this and because paranoid individuals often lack the interpersonal skills to achieve conflict-free closeness, contact is achieved in the realm of imagination. This imaginary contact includes fantasies of attachment (often unrealistic, with images of merger, wordless understanding, twinship, etc.), which are simultaneously infiltrated by fantasies of aggression, attack, exploitation and enslavement.

It is often a daunting task for the therapist to approach a patient in such a frame of mind, and attempt to establish a "working alliance" based on trust and a realistic sense of who the therapist really is. Because these patients are steeped in the vigilant reading of cues from small bits of experience saturated with their own (often aggressive) fantasy life, the most benign behaviours by the therapist may be interpreted as manipulative attempts to attack or seduce. Waiting for the patient to become comfortable with the "friendly expanses surrounding the therapist" (Balint, 1959) may be a very long wait indeed. There is little of a "neutral" point of view (i.e. literally "common sense") distinct from their paranoid experience to help correct their suspicious distortions. When a therapist acts in a friendly way, it may not be experienced as supportive, but rather as a seductive and dangerous manipulation. Paranoid patients are caught in a vice, pressured by their need to affiliate on the one hand and by their fears of exploitation, manipulation, loss of identity and annihilation of the self on the other. Speaking about a vague group of persecutors, and probably referring to the therapist as well, one patient remarked, "People appear to be friendly, but that is subterfuge for their secret malice. Some people only feign trying to help."

Yet another problem in working with many paranoid patients is that they are often delusional. What I mean by this is that their experience of the outside world is determined by a structured and fixed version of reality created in their interior world. Their representation of the world is not designed to help with realistic adaptation. It is not, as it is for nonpsychotic individuals, a contingent "working model" of external reality that is modified and adjusted as new information about life warrants. Most nonpsychotic individuals approach reality with a de facto "scientific method"—that is, they intuitively develop a hypothesis about events, test that hypothesis by experience, and confirm or disconfirm it. In the light of what they have learned, they modify their schemas about what social and physical external reality is like. Individuals with delusions are different. They have a very difficult time "learning from experience". Their models of external reality are not really set up to help them adapt to real experience. Rather, they are designed to be a bulwark against long-standing inner dangers. Often, they are designed to prevent information from coming in from the external world. They remain stubbornly

resistant to new data, especially data about intimate social contact such as a relationship with a psychotherapist.

There is no simple or definitive approach to the paranoid patient. The technical dilemma is as follows: on the one hand, being a "friendly presence" usually generates only shallow contact, and is highly vulnerable to the patient's projection and displacement of persecutory fantasies that become experienced as real. In other words, the therapist will eventually be experienced as a hostile persecutor despite his attempt to maintain a friendly "status quo". The patient's paranoid fantasies will inevitably enter the transference. The lifespan of the therapist's status as a benign companion is often painfully short. Any frustration that generates anger is attributed to the therapist's intent, and he may be experienced as malevolent in short order. On the other hand, an attempt to avert this pathological outcome by interpreting more deeply runs the risk of making the patient feel invaded by the therapist's malevolent, magical and mind-reading attack. In the language of contemporary Kleinians, the patient's projections are too prematurely and forcibly pushed back into him.

Early Kleinians adopted a strategy of active intervention and made use of everyday material to make very deep interpretations of emotions mixed with images of body parts. The risk in this is that the patient's ego is not ready to assimilate these emotions and fantasies and at the same time remain coherent. The patient may recoil from what he perceives as a dangerous assault. He may feel pushed to protect himself by using ego-dividing (and thus ego-weakening) defences such as massive splitting and primitive denial. Feeling attacked, he may withdraw, which leads to virtually the same experience of the therapist as persecutory that resulted from the "watching and waiting" stance.

The psychotherapy of paranoid psychotic patients, then, is filled with risks. The therapist must be patient and intuitive, alert to those moments when either support or interpretation will make a decisive difference. Overall, some combination of respectful listening, emotional availability, confrontation of ego-weakening defences and interpretation of the patient's aggression and fear of attack will be necessary. Hopefully there will be enough of a residual nonpsychotic part of the personality that is able to bear the intense anxiety and guilt that intense emotions stir up for the patient to learn from this psychotherapy experience. It is the nonpsychotic part of the patient's personality (Bion, 1957: 43–64) with whom the therapist must make an alliance. Needless to say, working with these patients can be extremely delicate, risky and painstaking. Despite its very real rewards, it can be a significant emotional strain for the therapist.

The capacity for curiosity and self-reflection: some case examples

Mr. Roberts: the breakdown of curiosity and self-reflection

Mr. Roberts, a man with a long-standing diagnosis of schizophrenia, came to sessions reluctantly. He was very guarded and spoke quickly. He used a

language that seemed "coded"; that is, in which a variety of particular words were used over and over. The earnest tone in his voice suggested that these words communicated great personal meaning. In Mr. Roberts' mind, the doctor was already familiar with the meanings of these terms. He was not. Mr. Roberts spoke with emphasis, at times serious, at other times angry, but always as if his meaning was self-evident. Mr. Roberts' tone was righteously indignant. "We are not here to fool around," he scolded. "You must help me immediately." He believed that he was being tortured by terrorists. His torturers were forcing the "wrong beliefs" on him and drawing him into a "tangle of influence". He refused to endure this torture anymore. He refused to endure deception anymore.

Over time, Mr. Roberts became increasingly angry and suspicious. His therapist, Dr. J, tried to use the LEAP[1] approach, seeking to empathize and find areas of agreement so that he could help plan steps that both patient and therapist could work on together. But this was tough going.

At one point, Mr. Roberts reported that the army had bugged his room. He also heard a barely audible mumbling. He was convinced that these were insults directed at him. This made him "lose his mind". A colleague at work had been recruited by the military, he thought, and was planning an attack. Despite their former friendship, this man was now the enemy. In addition to his paranoid delusions, Mr. Roberts had marked looseness of association and tangentiality. He also had strange somatic sensations including soreness in his feet. The pain was sharp, like "nails sticking in my soles".

Mr. Roberts felt that Dr. J was part of a plot to disrupt and distort his thinking. He confronted the therapist: "Are you helping the army or not?" He said, "Entering into the circumstances gives space to the processes of malice." The therapist understood him to mean that exploring his emotions was painful and was making him worse. "It will only prolong disorder," Mr. Roberts said.

Despite his desperate unhappiness, Mr. Roberts seemed to have little curiosity about the cause of his experience. He had little interest in looking at what he was going through from different angles. It was as if he was living a horrifying dream but never had the thoughts: "Maybe this is only a dream. Perhaps I can wake up. Perhaps my impression of what is real is not so. Maybe I've got things wrong." He seemed unable to step back from his experience and observe it with curiosity. It was as if he needed his view of reality to be fixed in place, just as it was. It was as if his delusional view served some vital function.

Ms. Kelly: the survival of the capacity for curiosity and self-reflection

For some patients, paranoid delusions and a paranoid transference are a relatively small part of the overall symptom picture and these patients are, as a result, more ready to establish a working relationship with the therapist. While these treatments are fraught with difficulty, they at least have the advantage that the patient's

emotional and intellectual strengths can be used in the service of exploring the emotions and fantasies connected to their psychotic experience.

Even while they are delusional, some patients retain an ability to consider other views of what is real.

Norah Kelly believed that God's emissaries had chosen her to be "The Servant". Their ultimate goal was obscure, but she had been singled out for this task. She felt obliged to undergo tremendous suffering to help save mankind and experienced this as a kind of noble burden. Despite all this, Ms. Kelly was able to speculate about whether this was actually true. Maybe she suffered from a mental illness, she wondered. When the therapist asked about particular beliefs, Ms. Kelly was able to appreciate the unlikelihood of some of them.

The "process of reality testing"[2] remained at least intermittently intact. She was able to talk about relationships with friends and relatives with emotions that her therapist could empathize with. While entertaining delusional beliefs, she was also able to engage in workable human relations. This made it far easier for the therapist to enter into a therapeutic alliance. There was at least some shared interpersonal platform upon which to do psychotherapeutic work.

Social withdrawal and the dangers of intimacy

For a number of paranoid individuals, the social withdrawal that is designed to protect them ironically increases their fearfulness.

Mr. Watt said that when he felt more distant from his relatives, he became more suspicious. When he and his family were able to reconcile, the closeness seemed to usher in a more trusting attitude towards others.

Conversely, some people react to increased social contact with an exacerbation of mistrust. For them, it seems, the danger of being seduced and enslaved into a dangerous dependent relationship is paramount. They fear that another person will make use of their need for closeness to manipulate them. They fear that their needs for love will be exploited to betray and enslave them. For these patients, the increasing affection they feel for the therapist becomes an alarming danger.

A therapist worked with a patient with a severe paranoid character. On one occasion he spent extra time with the patient discussing the intimate details of his loneliness and sadness about the estrangement from his best friend. The patient appreciated the extra time spent. The patient came to the hospital for an unscheduled visit, and had to wait for the therapist to finish teaching a group of residents. The patient became enraged at what he perceived to be a slight. Subsequent meetings only exacerbated the patient's mistrust and anger and eventually he discontinued treatment altogether.

It seemed that the therapist's support had stirred up a wish for increased intimacy. That longing, in turn, triggered an expectation of abandonment, which led the patient to flee.

Susan Young: paranoid character and the fear of intimacy

Susan Young was a patient with a paranoid character. Despite the fact that she was not overtly psychotic, she was an example of someone experiencing a form fruste of paranoid psychosis, and her case offers insights into what are often deeply buried aspects of paranoid experience.

Ms. Young was a twenty-five-year-old woman who worked as an advertising executive. She was single and very involved with the neighbourhood Lutheran church. She had grown up with parents who both spent long hours at work. Her father was an investment banker and often not at home. Her mother was involved in town politics and was often at meetings during the evening. Ms. Young felt extremely lonely. She always believed that there was something wrong with her. Something about her, she thought, caused other people to keep their distance. She was constantly anxious and fearful that others would exclude her and betray her. She responded by adopting an attitude of cynicism towards affection and a righteous resentment about her past mistreatment. Life was unfair. Her longing for contact was buried beneath many layers of resentment and cynicism.

Ms. Young came to adopt a general attitude towards Dr. V. She had a scolding tone, expecting the therapist to let her down. She pointed out evidence of the therapist's insincerity and hypocrisy whenever she could. She needed proof that the therapist was devoted to her. She wanted her therapist to secure disability payments for her and to be in charge of coordinating her many medical visits. Finally, she demanded that her therapist authorize insurance payments for sessions that she had not attended. Without this, she said, she could not trust the therapist and no progress was possible. For her, Dr. V's viewpoint about his role was irrelevant.

Ms. Young also had very definite views about the attitudes of her church friends towards her. She insisted that her suspicious thoughts were not fanciful speculations. She was convinced that her friends hated her. She figured this out by means of nonverbal signs such as facial expressions, posture, tone of voice, etc. When the therapist suggested that these might reflect some of her own feelings about herself, she dismissed this idea with disdain. If Dr. V did not accept her judgments about reality, then there was no basis for a therapeutic relationship.

The therapist came to believe that there would be no limit to the proofs of her devotion required by Ms. Young. Since her mistrust had largely to do with her pre-formed need to protect herself from the dangers of depending, complicated by projections of her own hostility and her own urge to betray, this would be an exercise without an end. Dr. V declined to sign the insurance form and was prepared to face Ms. Young's indignant rage. She also interpreted Ms. Young's contempt and hostility as an effort to deny her own longing to be loved by the therapist. Dr. V said that Ms. Young's indignation and contempt might be compounded by missed visits over the Christmas holiday, leaving her feeling sad and hurt that the therapist's family was better loved than she was. Dr. V wondered if, at such moments, Ms. Young might feel that the therapist's concern was a pretense. Dr. V underscored the patient's wish to be soothed, cuddled and taken care of.

Ms. Young's tone changed dramatically. She became much more thoughtful and quietly contemplative. She acknowledged the truth of what the therapist had said. The session ended and Ms. Young smiled warmly as she left. She was, by degrees, able to discuss the emotions that lay behind her insistence on omnipotently controlling her therapist's behaviour. She acknowledged feeling weak and unlovable. She refused to offer her affection to anyone for fear that it would be rejected and that her own sense of value would shatter. The lowered self-esteem and the fragmenting of her self-experience that followed rejection felt unbearable. Her attempt to sadistically control the therapist and impose her view of reality on her preserved some vestige of self-respect and agency. Her scolding hostility protected her against a deep longing to surrender and be taken care of. Humiliating wishes to surrender, moreover, were connected with frightening sadomasochistic fantasies.

In the following weeks, Ms. Young was able to elaborate further on her fears. Her loneliness and longing had made her feel weak and ashamed. She feared that because her longing to be taken care of was so deep, she would lose her self-control, and would be willing to be taken advantage of if this would lead to contact with a man. She would be willing to be turned into a kind of Geisha, catering to her partner. It would be degrading. She said, "Who will ever volunteer to take care of me the way I need?" Feeling frustrated and helpless about experiencing intimacy, she said, "I feel like destroying everything."

Ms. Young was a woman with many ego strengths and talents. She was able to function at work and to sustain at least a few long-term relationships. We can picture how much more intense and disorganizing are the fantasies of people experiencing chronic psychotic states. Given the difficulties that people diagnosed with schizophrenia have in tolerating strong emotion and in putting emotions into language, it is no wonder that they do not open themselves up to more intimate contact with others.

A disastrous developmental bind

People experiencing paranoia live in a tormenting bind. They depend, as we all do, on the care of others to develop a coherent sense of self.[3] Usually that process takes place in childhood when relatively few demands are made on the infant in terms of function and adaptation to reality. The connection to the mother helps the child assemble (from fragments of self-experience) a whole, integrated, coherent self. The mother helps to make the transition from omnipotent fantasies of control over events to a more realistic and limited view that is better adapted to the child's actual skills and powers. The self becomes simultaneously both more limited and more effective. Children depend on their parents to create an environment of safety in which, free from excessive impingements, they can have access to spontaneous and genuine inner experiences that will define their authentic selves. The self, so developed, becomes an integrated "personal unit". The mother's "holding environment" provides the time and emotional space for this to occur without the

premature strain of adapting to reality before the child is able or ready. In this way, the self comes to feel genuine, effective and alive.

The failure to experience this kind of an environment can be disastrous. According to Winnicott, this can lead to the development of a "false self" that hides and protects the "true self" from exploitation. In paranoid patients, this false self is a fragile shell. This shell remains vulnerable to impingements, fragmentation into psychosis and overall annihilation (Winnicott, 1960). The patient stands on the brink. He cannot bear his lonely and deadened life as it is, and yet he cannot imagine indulging in the kind of care-taking necessary to become an integrated personal unit. Permitting himself to depend on the therapist seems like an invitation to disaster—an invitation to abandonment or enslavement. The bind for paranoid patients is that on one hand, they desperately require a loving relationship to help them build an integrated self, and on the other, they desperately fear making human contact which threatens to obliterate what modicum of self they rely on to function. The danger of intimacy is that without being constantly on the alert to avoid seduction and influence, the patient fears that his truest self will be exploited and broken down. Once his true self is damaged, he loses his personal identity and ceases to exist as a specific person. This would be the ultimate psychological catastrophe. Paradoxically, in his urgency for closeness, he will allow the other person to invade him and take over his personality to the point of self-extinction. The wish to merge and the terror of it underlie the patient's paranoid fears. Such individuals are intensely humiliated by and fearful of their willingness to trade their identities for the experience of intimate union.

The adult in a psychotic state may yearn for and need a version of maternal holding, but within the framework of their adult relationships, this kind of care-taking has no mental representation. There is no language and no protocol in the usual course of life for an adult to put himself into the hands of another adult in this way. Such longings feel fantastical and impossible. There is no explicit cultural language that refers to this developmental need when it occurs in grown-ups. As a result, it goes underground, only to emerge in the form of obscure symptoms. When a patient in such a bind comes for treatment, he is faced with a disorienting choice. The therapist implicitly communicates that a trusting relationship is both therapeutically necessary and available. The patient's experience, however, tells him that to trust this offer would lead to a psychological calamity.

Technical dilemmas

The psychotherapy of paranoid patients is filled with pitfalls. Certain patients may have paranoid experiences that are limited to transference and do not deteriorate into frank psychosis. They are able to maintain an image of the therapist that is not completely corrupted by their suspiciousness and can manage to depend on him to a degree. They have the capacity to doubt a developing feeling of certainty that goes along with their paranoid view, and thus, strictly speaking, their beliefs can be considered "overvalued ideas". Other patients who are not necessarily

structurally psychotic may experience "transference psychoses" (Searles, 1965; Kernberg, 1975, 1984) and develop suspicious delusions that are limited to the psychotherapy setting. Still another group of patients have paranoid delusions both within the treatment and in the outside world.

There are no ready solutions for approaching the therapeutic dilemmas these patients present. The images of attack and counter-attack and emotional withdrawal will usually not change of their own accord. The therapist may feel it necessary to interpret primitive defences such as devaluation, projective identification, splitting, denial and omnipotent control that underlie a paranoid stance (Kernberg, 1975). Clinically, this can be extremely useful. But unlike work with many borderline patients, such interpretations often do not reduce the use of these defences (Kernberg, 1975, 1984). Patients with s psychotic structure may become more enraged, more paranoid, more confused or more psychotic following interpretations.

Ms. Chen: help me! / I don't need your help!

Ms. Chen had been in treatment for several years and had been doing well. However, over the course of about a month she became increasingly suspicious. She got into altercations with her fellow teachers, feeling that the public address system at her job was being used to disseminate hostile messages about her. Finally, she called the assistant principal to her classroom to report accusations against her colleagues, and the administrator, in turn, called her therapist, Dr. N. When she next met with Dr. N, Ms. Chen appeared haggard and tense. She had not consulted with a psychopharmacologist as Dr. N had recommended. When Dr. N asked her about what had happened at school, Ms. Chen tensed further and felt that the therapist was intruding. She said she felt as if there was a "dental instrument pushing on my skull".

Ms. Chen had precipitated a crisis that created all kinds of dangers for her, both social and financial. While she implicitly was asking the therapist to help by giving the assistant principal her telephone number, she bristled at Dr. N's request for details and gave the impression that she was taking care of things just fine on her own. She said, "I don't pay you to teach me things; I pay you to listen." Essentially, she denied the call for help implied in the crisis she had created. She was furious with Dr. N for not sharing her own view of reality. At this point, she could not tolerate that there could be two very different, incompatible views of what was real. If Dr. N did not see the world the way she did, then Dr. N was part of the problem, and was against her.

During her meeting with Ms. Chen, Dr. N tried both to obtain details about what had happened, and also to point out that although she and the patient saw the world very differently, this did not necessarily mean they could not work together. Dr. N also pointed out how furious Ms. Chen was, and how that made it difficult for her to trust others, including the therapist. After a few more meetings, the patient stopped coming to her sessions. The therapist later found out from

her relatives that the patient had been extremely upset because her boyfriend had criticized her for forgetting to buy concert tickets. The patient became massively enraged, and then withdrew.

Paranoia: a variety of outcomes

Mr. Martin: an unsuccessful confrontation of aggression and paranoid defences

Mr. Martin was a twenty-five-year-old accountant who had never been hospitalized or overtly psychotic. He had at least one and possibly two first-degree relatives who were diagnosed with schizophrenia. On the surface, he appeared to be suffering from narcissistic personality disorder. He depended on others inordinately for his self-esteem, and became enraged when he was disappointed. There was a haughty quality to him, and his idealization of others was often followed by bitter devaluation and contempt. He used splitting and projective identification prominently as defences. His superego functioning was inconsistent, and while he excoriated others for dishonesty and disloyalty to him, he rationalized his own dishonesties and petty thefts (he periodically shoplifted).

Mr. Martin had little tolerance for guilt, and usually projected responsibility for destructiveness onto others, maintaining an image of himself as a victim. He appeared to relate to the therapist in the transference as both confirmer of his ideas and values, and as an ally against those who did not understand him. As long as the therapist did not question his feelings or behaviour, he saw her in a positive light. When the therapist asked about incidents in which he had become suspiciously hostile, or interpreted his primitive defences, Mr. Martin became guarded and angry.

Mr. Martin's symptoms were exacerbated when his girlfriend of several years left to take a job in another city. He became agitated and suspicious. He felt both hostile towards and in need of this woman. He visited her at work to excoriate her. Despite his anger at her, he could not refrain from making some kind of contact. He felt both furious and tormented for weeks.

Gradually, his behaviour deteriorated. He got into conflicts with the law (for shoplifting and disturbing the peace) and came to several sessions high on drugs. The therapist, Dr. R, pointed out the self-destructive nature of his behaviour. She pointed out the two very different views that Mr. Martin had of his girlfriend (splitting) and how he experienced those he hated as persecuting him (projective identification). She raised the question of whether his self-destructive behaviour communicated a criticism of his girlfriend and herself for not caring for him enough. He became overtly psychotic and developed delusional beliefs about the therapist and his girlfriend. Active interpretation of his rage, self-destructiveness and primitive defences did not reduce his symptomatology. According to Kernberg's criteria, it is possible that Mr. Martin had an underlying psychotic structure. Over a long period of time, he eventually re-compensated.

Mr. Tilden: a successful confrontation of aggression and paranoid defences

Here is another example. Mr. Tilden let slip a disparaging remark about the therapist's country of origin. This comment was made in passing, and at least, on the surface, was directed against someone else. The therapist chose to explore the comment because the sessions had recently seemed quite empty and superficial and because she believed that it would be useful to explore the patient's aggressive feelings.

When Dr. T asked him about his remark, he became hostile. Why was she picking on his comment? Other things were more important to discuss. Why did Dr. T always have to be in charge of what he talked about? Mr. Tilden insisted that Dr. T not interfere with his talking again. When Dr. T pointed out Mr Tilden's need to control her behaviour, he became even angrier. He called her corrupt and domineering. He insisted that Dr. T wanted to control him, and that she wanted to pursue her point until he knuckled under. Mr. Tilden's positive feelings about Dr. T seemed to disappear. Dr. T pointed out his tendency to see her as all bad when he was angry, and to assume that she was feeling as hostile to him as he was to her.

At this point, Dr. T stopped talking and listened. Mr. Tilden continued to bristle, but also sporadically acknowledged that there was a hostile side to him. In the next session, he spontaneously talked about his feelings of hatred and said that it was a very painful subject to get into. He knew that he had destructive feelings, he said, but he didn't like the way the therapist was pointing them out. He realized that he avoided discussing this side of himself, and thought this would be a slow process. If Dr. T kept cornering him about these feelings, he was not going to be able to discuss them. In any event, to talk about these feelings with the therapist would make him very vulnerable. It was scary to be exposed to someone. It was also scary to admit how much he needed from Dr. T and how much he wanted her to soothe him.

Mr. Tilden and his therapist went on to talk about both his angry feelings and his defensive use of cryptic language to distance himself from her.

The cases presented above demonstrate very different therapeutic outcomes. Transference interpretations of primitive defences and impulses did not seem to help Ms. Chen or Mr. Martin. Both seemed to be in some kind of extremis in which they needed to maintain the view that destructiveness was outside them, not inside them, and that they were victims, not perpetrators. Whether this was so because of an intolerance of guilt, or for some other reason, is not clear. Mr. Tilden, on the other hand, did benefit from interpretations of his use of projective identification and omnipotent control. Although he clearly was not pleased to confront his own aggression, he was able to tolerate the blow to his self-esteem that was involved and to maintain a positive tie to the therapist.

The need for human contact and the dangers of it

The need for human contact is universal. However one conceptualizes this need, whether as a form of inborn object-seeking (Fairbairn, 1944), as a wish for

the validation and soothing of a self-object (Kohut, 1971), or as a longing for intersubjectivity and communion (Stern, 1985), human beings find comfort and fulfilment in relationships. However, to negotiate an approach to the other, an individual must be able to tolerate frustration, delay, uncertainty, anger, disappointment, disillusionment, rejection, sadness, humiliation and, at least to some degree, a sense of impotence. One can speculate about what makes it possible for one patient to endure these dangers and maintain an affectionate tie to the therapist, while another becomes suspicious and breaks off the treatment relationship. One can speculate that a successful patient, Mr. Tilden for example, experienced some basic nurturing in his development that sustained the hope of rewarding contact. One can speculate about inborn or developmentally acquired differences in destructiveness, or the way in which destructiveness is metabolized psychically. One can imagine that the capacity for self-soothing and turning to the self for love and comfort varies among children as they grow, and that such self-soothing permits hope for contact to survive in secret. There are so many factors that influence the capacity to preserve faith in loving and being loved that it is difficult to pinpoint which of these factors operate in a specific case. What I have said about the vulnerability to paranoid withdrawal and the loss of faith in human goodness is descriptive. What it is in development that fosters or kills the capacity for such faith may remain a mystery in any one particular individual, but it is possible to develop ideas that add to our general understanding.

Both Ms. Chen's and Mr. Martin's paranoid episodes began with blows to their self-esteem. Ms. Chen spoke of her "fractured image", and how, years before, she had felt that her mind was literally composed of shit. Paranoid reactions to feelings of worthlessness solve several psychic dilemmas. First, they locate the badness in another person, by means of denial and projection. "They" and not the self are worthless, cruel, guilty or evil. Second, these paranoid responses establish a distance between the self and the object that protects against further "impingements" (Winnicott, 1960) from the outside. The less one values the other, and the less contact one has, the less that other can hurt and shatter one's fragile sense of ongoing being. Excessive closeness and therefore vulnerability is avoided, while the experience of human importance is maintained even if only in fantasy (Auchincloss and Weiss, 1992).

The challenge of doing psychotherapy with paranoid patients

Work with paranoid psychotic patients is, at best, difficult and taxing. The therapist must make a steady emotional investment that is often spurned and dismissed by the patient in word and action. The therapist will often doubt both the wisdom of his technical approach and the wisdom of his emotional investment. Progress is often slow and fragile, susceptible to sudden and dramatic reversals. Sometimes patients, for no apparent reason, will suddenly abandon the relationship altogether. Countertransference emotions may run very high and the therapist

may suffer under the devaluation of his commitment, concern and affection for the patient. Intense anger and disappointment with the patient are commonplace. Nevertheless, there is little alternative to the therapist's approaching the patient with a combination of concern, respectful attention to the patient's aggression and devaluation, and sensitivity to the patient's need to preserve his personal identity.

Notes

1 "LEAP" stands for Listen-Empathize-Agree-Partner. See Amador, 2010.
2 See Chapter 10.
3 See Winnicott, 1960.

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9

TWO CLINICAL SYNDROMES

The shattered self and the wish to be a Messiah

The shattered self

The feeling that one's self is composed of fragments that do not fit together is unusual for most of us. We have all had experiences of feeling unlike our usual selves due to physical illness, exhaustion or even travel to different cultures where the usual markers of who we are are absent. Probably all of us, at least in passing, have had the sensation of feeling alien, or oddly different than we are accustomed. But feeling that we are broken into fragments and that we have utterly lost the feeling of a secure and constant self goes beyond our usual experience and is one of the hallmarks of psychosis. Some people with psychosis, for biological or psychological reasons, have been transported to a region of blunted emotion, social isolation and apathy. These individuals may also suffer a sense that they are broken up and not whole. They suffer not only from feeling odd and unlike other human beings, but also from a feeling that they have no enduring, reliable, settled self-experience. They have no "personal home base". Random, pointless experience replaces a feeling of meaningful agency and a coherent life narrative. The words they use to describe their experience are: shattered, in pieces, broken up, split up, fragmented and strange.

Here are a few examples:

Claudia Sanchez was a woman given a diagnosis of schizophrenia in her late teens (see Chapter 7). She often felt that her self was in pieces. This was connected with the feeling that her body was altered. She sometimes felt that it was somehow like a vapour, that it wasn't really solid. This experience left her frightened, exhausted and confused.

Steven Tilden was a quasi-psychotic man[1] who suffered at times from incapacitating anxiety, and irrational beliefs that bordered on delusions. When stressed, he experienced end-of-the-world fantasies similar to those described by psychotic patients. He often had tremendous difficulty concentrating and was socially isolated for long periods of time. He said, "I feel splintered. It's like I'm thrown all over the ground. Sometimes it's like I'm a glass table top with a crack running through it."

Susan Young was a 27-year-old woman with a severe paranoid character. She commented, "I have a feeling of not being unified . . . physically. There is a strange feeling of being cracked into pieces. My sense of myself is so fragile."

James Kelly was a man diagnosed with schizophrenia over the course of many hospitalizations. Like Claudia Sanchez, he felt that his body had changed, especially his voice. He was so preoccupied with the sound of his voice that he could concentrate on nothing else. The rest of the world seemed to fade away, into the background. He said, "My preoccupation with my voice comes between me and my peace of mind."

Sometimes the feeling of being shattered is connected to a sense not only that one's own perceptions are in pieces, but that the outside world, too, is in fragments.

Ms. Sanchez said that her perception was not working as it used to. When she encountered objects, they seemed "broken up" and "scattered". On top of that, events seemed to occur in random sequences without a sense of continuity or human purpose to them.

This last point is important. The odd and alien physical experiences these patients describe go together with a feeling of being unreal and of drifting aimlessly through time. There is no sense of meaning to what they do, or what happens to them. There is a deep sense of futility.

"Nothing happens for any good reason," Mr. Kelly said.

Ms. Sanchez commented, "I go to my clinic in a daze. I don't feel like doing anything. Ms. O (a persecuting voice) screams at me every second. I feel trampled. I have no energy or motivation to do anything anymore. I just want to crawl into a cave and hide." She added, "I've lost my old self. It's like my self has been obliterated. Existing without a self is agony. Can an illness destroy your self?"

The loss of a personal identity is very painful for these patients. Some philosophers such as Hume and Diderot, and some psychoanalysts such as Lacan, have held that the ego is a protective social construct used as a defence against existential anxieties. However, the patients I have described experience the absence of a core self as palpable and disturbing. They mourn the loss of a coherent centre of desire, wish and intention. They feel active pain because of the absence of meaning and purpose that they associate with a central "self". They do not feel core affects that signal to them the state of their deepest, personal centre. The absence of a self is not accompanied by a sense of liberation from a defensive fiction that holds them back. Rather, it is devastating. It feels like the loss of a lynchpin that anchors and structures daily life.

So, in what does this "loss of self" in psychosis and related conditions consist? One possible answer is that the loss of self in psychosis is a byproduct of whatever biochemical, genetic or neurodevelopmental disease process is at work in the illness. Apathy, autism, loss of affect and cognitive disorganization have been considered classic features of schizophrenic psychosis since Bleuler's time. They have been incorporated into the concept of "negative symptoms" for which a variety of biological explanations have been offered. But while

some of these negative symptom syndromes may have biological correlates, it is important to see if we can identify psychological factors at work as well. The symptoms and dysfunctions seen in schizophrenia may be due to a rather wide variety of causes, some biological and some psychological. A number of studies show that positive symptoms such as hallucinations, paranoid ideas and delusions can be the product of psychological stress (Hamner et al., 2000). There is substantial evidence that negative symptoms such as flattened affect and apathy can also result from psychological causes (Hamner et al., 2000; Doerr-Zegers et al., 1992).

Social isolation, social withdrawal and the shattered self

Feeling unreal and broken into pieces is associated with the experience of isolation and disconnection from others.

When Ms. Sanchez was on her way to the clinic, she often felt that she had lost her self. This self-loss seemed connected to the absence of people around her. When she arrived at a place she felt was friendly and supportive, she once again felt human and real, "like a person", she said. There was something soothing and humanizing about this experience. When she felt someone reached out to her personally, she once again felt that she had a personal identity. When she was alone, by contrast, she felt broken and mechanical.

Part of Ms. Sanchez' feeling of self seemed to have to do with the behaviour of others.

If others reached out to her, she felt wanted and that her existence had some meaning. "My value," she said, "comes in connecting to people." At her clinic, she felt a special bond with another patient, who shared some of her interests. Talking with her was comforting. Later on, Ms. Sanchez joined a choir. After practice, some of the singers would go out to dinner. Her feeling accepted by this group was a decisive feature of her feeling that she had a self. She felt an intense sense of joy when she felt linked to others, and was thrown into despair and torment when this was interrupted. Sometimes, if she was not functioning well at her clinic job, she felt crippling self-doubts that developed into a sense of being different and isolated from others. Her feeling of awkwardness and isolation would escalate into a full-blown experience that her self had fallen into pieces. It was as if she had been relocated to a different universe, far away from human contact. She felt mechanical and lifeless, like her emotions had been compressed into a thin cookie sheet. This plunged her back into despair.

Susan Young said that she never, ever really felt quite real. It was as if there were a geological fault in the heart of her. If she let people near her centre, maybe they would exploit this weakness and hurt her. She linked this geological fault to her never really having felt that she belonged with other people. Ms. Young felt intensely suspicious of others, and held herself back from them out of fear of attack, disappointment and betrayal. She described an encounter with a former friend, when they met at a school reunion. The friend suddenly stopped listening

to her and began to talk about himself instead. She felt suddenly rejected and abandoned.

Ms. Young said, "It's like being on a raft made of ice which starts to crack. You just start to sink and there's nothing to hold on to. You go under. You just cease to exist. It's unbearable." Later, she said, "It's like I've been excommunicated from human contact. I can't stand the pain of not being accepted." "This emotion," she explained, "makes me want to run away from reality and make a private world of my own." Later in her treatment Ms. Young was able to feel some human connection to her therapist. On the way home from sessions, she would think of her favourite poems, and somehow, feeling moved and touched, in some inexpressible way, she felt the pieces of herself "join together". She said that she felt enough warmth (referring to contact with the therapist) that these pieces could coalesce. Later, she compared the sense of safety that permitted her to come together into a self as "like sleeping on God's shoulder". At these moments, "There is no threat that I feel I have to protect myself from . . . I can let go."

In some cases it is not clear whether the loss of a personal self precedes or follows the feeling of being disconnected from others. Sometimes for Ms. Sanchez, the change in self feeling seemed to come first. At these moments, her sense that she had an altered body made her feel so preoccupied, awkward and alien that she was afraid to make contact with others. At other times, her social isolation seemed to precede the feeling that her self had changed. She often felt assaulted by an inner force (personified by the voice of Ms. O). This force demeaned and screamed at her like a hurricane. When Ms. O snarled at her, she felt unable to make a bond with anyone else. The loss of human contact led by degrees to the feeling that she had lost her personal self. In Ms. Kelly's case, the feeling that his self had changed and that his voice had been altered led him to keep his distance from others. For Ms. Young and Mr. Tilden, their intense mistrust of others, and fear of being exploited, lay beneath the distance they kept. The change in their sense of self seemed to follow.

Whether the loss of self precedes or follows social isolation, we can understand some of the psychological factors that contribute to the feeling of having a shattered or deadened self. Fairbairn wrote about the effects of emotional disconnection in schizoid patients. He said, "What emerges as clearly as anything else from the analysis of such a case is that the greatest need of a child is to obtain conclusive assurance (a) that he is genuinely loved as a person by his parents, and (b) that his parents genuinely accept his love" (1941: 39–40). He went on, "Frustration of his desire to be loved as a person and to have his love accepted is the greatest trauma that a child can experience." Fairbairn's account emphasizes two separate experiences: the experience of being loved as a person, and the experience of having one's love accepted. If either experience is absent, the child will withdraw from human contact. The consequence of emotional withdrawal is critical for the fate of the self. When the self withdraws from human contact, it loses its feeling of meaning, purpose and aliveness and, in the end, its coherence.

Fairbairn wrote of the schizoid person, "He becomes afraid to love; and therefore he erects barriers between his objects and himself . . . all interest in the world

around fades and everything becomes meaningless." He emphasized the changes in the self that take place when object relations are renounced. Withdrawal from others "reduces the ego to a state of utter impotence. The ego becomes quite incapable of expressing itself; and, insofar as this is so, its very existence becomes compromised." Fairbairn continued, "In renouncing libido . . . the ego renounces the very form of energy which holds it together; and the ego thus becomes lost." Sigmund Freud also emphasized the relationship between the capacity to love and psychic health. He said, "We must begin to love in order not to fall ill, and we are bound to fall ill, if, in consequence of frustration, we are unable to love" (1914: 85).

The idea that emotional withdrawal undermines the motivation of the self to live, and ultimately, then, its very coherence, I think accounts for a great deal of what we see in the patients I have described. Despite their intense symptoms, each of these patients still cared a great deal about their relationships with others. The experience of having a shattered self seemed to revolve around their feeling of connectedness.

Ms. Sanchez said that when her friend hugged her, she felt "like a real self, with an identity." "I felt like a person again, not a machine," she explained. She continued, "When I feel like that after feeling shattered, it's like a tranquilizer has calmed me down."

Mr. Tilden described the sense of feeling accepted or loved in this way: "It's like sunlight, it's warm and comforting."

Ms. Sanchez, Ms. Young and Mr. Tilden all emphasized that it was not simply being loved or accepted by others that made them feel more whole. It was experiencing the feeling of love for someone else and feeling that their own love had value that was crucial.

Ms. Sanchez remarked that when she was with her choir, she felt such affection that her hallucination of Ms. O faded away. She believed that her ability to feel love for others was linked to feeling whole. Her sense of self returned when she was helping out other people at the clinic. "I feel like my value is in giving something to other people."

Ms. Young also emphasized how important it was to her that her affection was accepted. She said "When I try to be friendly, and it's pushed away, I feel pointless, and it's like I cease to exist. It's as if I'm not real or something." She went on: "It's like being completely erased. I feel like I'm fading away. It's like my emotions fall down a black hole and disappear." She added, "This is why I think that until you're able to care for somebody, truly, you can't really get better."

Mr. Tilden said something very similar. "I need someone to give my love to. Beyond anything else, that's the basic thing. I feel you (his therapist) appreciate my affection. Especially after I've been so angry at you. It makes me feel I've given you something and made up for my destructiveness. It makes me feel that I'm entitled to come together, to be myself, and to not be shattered anymore."

This last comment by Mr. Tilden is intriguing and implies that there is a moral dimension to feeling a personal identity. If a person experiences himself as too

destructive, too toxic and too monstrous, he may feel obliged to experience himself as shattered. First, the feeling of a shattered self, for most people, is exceedingly painful, and can serve as a powerful self-punishment. Second, as we shall see again later on, experiencing oneself as shattered can serve important defensive functions. A person who sees himself as a monster or killer may feel shattered as a reassurance that he does not pose a danger to his loved ones.

For example, Ms. Sanchez had intrusive fantasies that she was a vicious assassin. This terrified her. She tried to disavow her hostility over and over again. When she was most symptomatic, she had the conscious and horrifying wish to murder her younger brother, who had achieved success in his career. It seemed to her therapist that her feeling shattered had to do with a need to disarm herself by rendering her will, her desire and her cognitive skills impotent.

Beyond this, a person may feel that his basic needs impose a painful burden on those around him. Instead of forming a self, who has clear, concrete needs, he may wish to remain indistinct, needing and wanting very little.

Ms. Young said that to be invisible, although painful, was reassuring to her. "To need things from others," she said, "is to have an outline, a form, and an identity—which imposes your needs on other people . . . To take a clear-cut form is to run the risk that people will see who you really are and what your needs really are. Then they may say, 'You're too needy and repulsive . . . go away.'"

The formlessness of the shattered self may protect the person against crystallizing an identity that is either too humiliating or too unacceptable to others.

Anger and the shattered self

Patients discuss a number of ways in which anger enters into their sense of having a shattered self.

Ms. Sanchez felt agitated when she was alone. She felt like she was an "engine" that was all revved up. She felt hostile and that she had to move about. She was unable to act effectively. Her inner hostility seemed to tear at her. She connected this angry, self-annihilating state to the fact that she was alone. She contrasted this state with the warm, reassuring and connected feeling she had with her fellow choir members. She added that when she pulled back from people and felt alone, hostility churned inside her. It was at this point that she seemed to fragment and lose a sense of having a self.

Mr. Tilden explicitly connected his feeling shattered to anger that came from himself. "When I get so mad," he said, "I feel so destructive." He added, "I feel I don't have the right to be a whole, confident self. Then I feel I'm in pieces again. My hatred spoils my love." Mr. Tilden felt morally unworthy of consolidating his self into an "integrated unit" who asserted and satisfied his own needs.

Sometimes this inner, self-fragmenting hostility takes the form of an inner voice such as that of Ms. O.

Ms. Sanchez often felt at the mercy of Ms. O, who, just as she was waking up, would assault her with threats and verbal attacks. She felt crushed by the violence

of Ms. O's attack. It sapped her hopefulness and optimism for living. Ms. Sanchez felt beaten down, embarrassed and helpless in the face of such a violent force. It felt as if her self and her soul had been destroyed. This oppression at the hands of Ms. O made her furious. Over time she was able to reveal specific fantasies of murdering Ms. O. This, in turn, horrified her. At this point she said that defying Ms. O would do no good. Somehow Ms. O's power would feed on her own rage, and Ms. O would become even more terrifying. Eventually, Ms. Sanchez connected her picture of Ms. O as a brutal murderer with her own forceful and terrifying hostility. She recalled a fantasy in which she was a member of a crew of hit men. It felt like Ms. O murdered her every day. Ms. Sanchez wanted to know the following: if Ms. O was so horrifying, and she, Ms. Sanchez, created this image in her own mind, why would she want to keep an attacker like Ms. O so close? In discussing this, Ms. Sanchez remembered that at one time, Ms. O felt like an encouraging guide, who had helped her reclaim her life. She had felt a tremendous sense of gratitude and debt. At some point, Ms. O turned into a persecutor. She crushed Ms Sanchez' sense of pleasure, and even her motivation to contribute to others by making the patient feel worthless. Maybe, she wondered, Ms. O was still keeping her company, but now in a brutal sort of way. At this point the relationship with Ms. O seemed impossible to tolerate, but at the same time, impossible to do without.

When Ms. Young described the breaking up of her self, she emphasized the role that she, herself, played in it. She did not experience it as a bewildering flood of affect, or the attack of a fantastic persecutor, but more as a defensive strategy of her own. She said, "I felt shattered. Then I thought, did I shatter myself somehow?" On thinking about it further, she wondered whether she broke herself up to escape the fear of being attacked. She said, "It's like you're a spy in a foreign country. You have enemy agents tracking you. As soon as they know where you are, you're dead. If I can stay invisible or hidden, I might be safe. You can't afford to expose yourself or disclose anything personal about you to anyone. Being diffuse and in bits and pieces feels safe, so I don't have a defined position for them to track down. Maybe this is why my self feels so fuzzy and abstract. I don't connect up with where and who I really am."

Ms. Sanchez experienced her inner state to be like a war zone. She was continuously invaded either by emotions stirred up by others, or by Ms. O whose assaults got in the way of her "coalescing as a unit". Only when she felt interpersonally safe and calm could she feel the return of her "old self".

The presence of hatred or destructiveness beyond a certain intensity, whether it came from the actions of others, or whether it sprang from the patient's own hostile motives, acted as "impingements" on Ms. Sanchez, Mr. Tilden and Ms. Young. These impingements seemed to make it feel unsafe for them to allow the pieces of self to come together.

Ms. Sanchez, for example, felt locked in a life and death struggle with Ms. O. The more she hated Ms. O, the more afraid she became and the more this hostile relationship made her feel persecuted and unsafe. Little consolidating of the self could occur in this wartime environment.

The hidden self

To protect themselves from enemies, several patients spoke of the need to camouflage and hide their "true" selves. I noted this above in discussing Ms. Young.

Ms. Young spoke of this in detail. She said that she developed a second self to take care of and hide the one that was deeper, more personal and more real. The second self was like a decoy, standing in for the first, whose purpose was to draw the enemy's attack. She despaired of her real self ever leaving this deeply hidden bunker. Months later, she was able to feel that it might be safe enough to come out of hiding, and reveal herself to the therapist. "Maybe it's safer now to put together the pieces I've divided myself into," she said. "I don't feel preoccupied so much with the feeling of danger now. I feel protected here today. It's like nestling into your mother's lap."

We might understand this clinical material in the light of some of Winnicott's ideas about development. Under the right circumstances, if the holding environment provided by the parents is able to spare the child excessive "impingements" in its sense of continuity, the child is able to come together "into a unit" (Winnicott, 1958). The self that forms has a feeling of authenticity that differs from the feeling of a self that merely complies with social demands. There is something original about this kind of self, something spontaneous. Winnicott refers to this genuine element as the "personal impulse". When intrusions or impingements are kept to a minimum, the infant can discover this "personal" kind of living.

For Winnicott, there are particular psychological dangers when the self feels excessively impinged upon or exploited. It must be the intent of another self (the mother) to protect this delicate process from excessive disruption. If the self is excessively invaded, several things may occur. The child may develop a false self (similar to the alter ego of Ms. Young that looks genuine, but that is really a decoy). This false self lives almost as if the true self might, but its purpose ultimately is to comply with social demands to guard against exploitation, disintegration or annihilation. Excessive living within the false self generates a sense of futility.

Ms. Young used her self fragmentation as camouflage, hiding the "position" and identity of her true self. She sought safety in the experience of dissipation and invisibility. She was afraid that if she coalesced into a unit, a well-defined self, her enemies would locate her and attack.

We should note that the experience of being at war with others can have a temporarily organizing effect on self-experience. People who feel a loss often experience a sad listlessness that makes them feel passive, pathetic and inert. Under these circumstances, the self feels weak, defeated and lifeless. It is often difficult for the person to tolerate this depressed state. Mobilizing oneself against an enemy (i.e. adopting a paranoid stance) may help the person feel more invigorated, focused and sharp. It can lead, temporarily, to a feeling of self that is bold and decisive, with a coherent identity that one can take pride in. Rather than

feeling lethargic and passive in the face of loss, the person suddenly acquires a sense of value and purpose in fighting those who are wilfully trying to make him feel weak and small.

In the long run, however, this strategy has a cost. The embattled individual comes to feel even more distant and cut off from others, always vigilant and on guard, and even less able to find comfort in human contact. The loss of emotional support is defended against by an illusion of self-sufficiency. Progressively, the individual feels more and more alone in an increasingly hostile world. The temporary gain of a feeling of effectiveness, agency and self-esteem achieved by a combative, paranoid stance gives way to a feeling of futile isolation.

As I noted above, Ms. Young spoke of "hiding a deeper self" to protect her from her enemies. A number of patients refer to protecting a deep, genuine or real self from exploitation and attack by hiding it in a place that is secret and camouflaged.

Mr. Green was a patient with borderline personality organization with severe self-destructiveness. His symptoms represented a forme fruste of psychotic withdrawal. He said of his hidden, true self, "I can tell you, I'm in there somewhere. I feel it. My self is down in there and it wants to stay in its hiding place . . . It doesn't want to come out into your office, or anywhere." He linked the hiding away of his genuine self to feeling unbearably worthless and alone. "I felt so isolated, so utterly by myself. I couldn't take it. I thought it was better if the world was rid of me." He went on, "It's like I have this fragile self hidden in an inner intensive care unit. Maybe someone will help me take care of this sick self, and bring it back to life."

Mr. Green explained that his self had remained hidden for years, until it seemed like there was some hope that if it revealed itself in the relationship with the therapist, it would not be annihilated. But something in him fought against coming out of hiding. The risk of being discovered only to be exploited and violated felt unbearable. He threw up all sorts of distractions in his psychotherapy to prevent this core self from being revealed.

Ms. Young's feelings were very much the same. She believed that she had an actual self that was not fake, which was hidden away somewhere, but that it did not dare make an appearance with people. This real self was, she said, was like a hostage, locked away in an abandoned warehouse. This self was starving and filthy. Who would want to rescue such a self—to pick up such a disgusting creature and bring her to safety?

Psychotherapy with patients who have a shattered self

In general, most of the patients I have talked about made significant progress in their psychotherapy.

Ms. Sanchez, the young woman diagnosed with schizophrenia, was beset for many years with the voice of Ms. O. She had been living by herself in California.

She had no friends and no job. After several years of psychotherapy, she held several jobs that supported her, and was able to return to college, where she did very well. In addition, she now had a romantic relationship with a coworker.

While Ms. Young's relationships were still infused with aggression, there were now limited areas in which she felt a sense of pride and effectiveness. At these times her paranoid stance softened and she was capable of feeling more open, more tender and more hopeful. She felt less systematically vigilant, and was capable of feeling soothed.

Mr. Tilden was far less combative, and much more able to depend on other people and tolerate their imperfections. He was also capable of feeling comforted and soothed by another person. He said "At this stage, it's like my self can 'crystallize'."

At this point, it is not possible to identify the factors that permitted some of these paranoid patients to benefit from psychotherapy. The patient's own determination and courage to bear and explore very painful feelings certainly played a major role. There may have been many specific and non-specific psychological and biological factors that helped them make use of the therapeutic relationship. But I think that understanding their experience of self fragmentation made a difference. At the least, they did not feel so alone in their sense of feeling alien and inhuman. Beyond that, discussing their sense of being shattered led them to talk about their difficulties in being loved and in loving, and their defensive needs for emotional isolation, which resulted in futility and hopelessness.

In addition, it seemed that when the patient felt more precisely understood in his feeling fragmented, he felt more personally recognized. This personal recognition had the quality of a "communion" between one self and another. This seemed to reduce the intensity of paranoid hostility for some patients. It also seemed to reduce the frequency with which they felt impinged upon. More generally, it seemed to create an experience of sanctuary or shelter in which it felt safer for the broken-off and hidden-away pieces of the patient to come out into the open and come together as one.

The wish to be a Messiah

In this section I will focus on two related subjects: the experience of talking to God and the person's belief that he is the Messiah. The hallucinated relationship with God is often the most important emotional experience in these people's lives. The Messianic mission calls on them to heal the world's suffering, often at great personal cost. It is pursued with a single-mindedness that is at odds with the disorganization in the rest of the person's life. I will speculate later about why I think this is so.

I will discuss three patients who were diagnosed with schizophrenia according to DSM-IV TR. For one of these patients, the sound of God's voice was unqualified delight. It was comforting, inspiring and motivating. For the two other patients, the experience of God was more confusing. Sometimes God's

voice made them feel that they had a sympathetic companion. At other times, the voice turned demanding and critical. The patients felt scolded, taken for granted, ordered about and threatened. If they were disloyal to their mission, they believed that they would be punished. What promised to be a special state of grace could turn into a nightmare.

The format of this section will be this: I will give brief descriptions of these patients and then discuss what I believe is the psychology of these complicated experiences. I will focus first on the experience of hearing the voice of God and its connection to the psychology of attachment, the regulation of self-esteem, moral conflict and aggression. I will then talk about the psychology of being the Messiah and its connection to development, especially moral conflicts concerning obligation and debt within the family.

Three cases

Norah Kelly was thirty years old when she began psychotherapy with Dr. Y. Her stepfather was an immigrant who had been a professional singer in Eastern Europe. He expected Ms. Kelly to follow in his footsteps and go beyond him. Ms. Kelly had been given singing and acting lessons since she was a girl, and her singing accomplishments had intense importance to her parents. The parents had a long and unhappy relationship characterized by distance and silence. As a girl, Ms. Kelly felt removed from her stepfather and sympathy for her mother.

Ms. Kelly had a five-year history of psychotic symptoms that included paranoid ideas, severe hypochondriasis, auditory hallucinations and disorganized thinking. In addition, she believed that she had been recruited by God. God had contacted her to head up a plan to save humanity from evil and suffering. It was not clear to her why she had been chosen. This was an obligation, about which she had no choice.

Ms. Kelly agonized about this assignment: "I have been forced to fulfil this task. I'm directed to save the world," she explained. Her life had been commandeered for the greater good and she was to sacrifice her personal needs. This made her frustrated and furious. She railed against her fate. It would be great just to go to a movie and enjoy it without having to think about saving mankind. At other moments, Ms. Kelly's mission gave her a tremendous sense of purpose: "It is an honour to forgo your needs for the benefit of the human race. It makes me feel honourable to do that."

Over a period of time, Ms. Kelly and her therapist were able to connect her Messianic ambition to her family's expectations of success in her career. They also connected it to her wish to rescue her beleaguered mother from her loneliness and isolation. The therapist also interpreted her wish to rescue both her parents from their unhappy marriage and her guilt about separating from her parents, leaving them to their own unfulfilled ambitions.

The next patient, Kavi Singh, was a thirty-year-old Hindi man who had a very long history of psychotic symptoms including auditory hallucinations,

paranoid ideas, delusions, emotional irritability, thought broadcasting and thought insertion. He had been an excellent athlete since childhood and believed that Krishna watched over him and that Krishna had revealed a special plan for the universe, in which he played a prominent role. He felt that he had an intimate relationship with Krishna who spoke directly to him, warning him of bad decisions and guiding him towards good ones.

Mr. Singh's therapy focused on his sense that his parents' marriage was emotionally empty. They had separated several times. Mr. Singh had been lethargic, apathetic and socially withdrawn for more than a year. Then rather abruptly, he developed a feeling that he and Krishna had a special bond. Soon after that, his functioning got dramatically better. His thought disorder diminished and his cognitive organization improved. He was less awkward socially. As he improved, he became more convinced that Krishna was directing his life. "Krishna is never far away," he said. He now focused on scrupulous ethical correctness. Krishna's moral advice gave him a certainty and confidence that contrasted with his previous confusion, apathy and self-doubt. He attended religious services regularly and spent evenings distributing food to the homeless.

Ms. Sanchez was a woman diagnosed with schizophrenia who had many psychiatric hospitalizations. Her symptoms included auditory hallucinations, paranoid ideas, difficulty organizing her thoughts, social isolation and somatic delusions. Often, she felt that she was in a fog, living among objects that somehow were not really solid. Ms. Sanchez heard the voice of Ms. O, an occupational therapist who had worked with her in the past. The voice was critical and demanding. It told her that she had a Messianic calling to rescue mankind. It told her that Ms. O was really St. Teresa and demanded that the patient serve her. At times the voice stopped but this provided no relief to Ms. Sanchez. She felt utterly desolate.

Ms. Sanchez began therapy with Dr. F. She spoke about the fact that her family seemed to both need her and to undermine her at the same time. Her mother was a competent woman, but distant. Her father was stern and critical. Her maternal grandmother had been very involved with her growing up, and at times Ms. Sanchez felt especially attached to her. At other moments, she felt that her grandmother was clingy and needy, demanding that she spend special time with her when she wanted to be with friends. This made her furious. She felt that her grandmother and mother wanted her to remain ill, so that she could stay with them forever.

Ms. Sanchez felt similarly trapped by the voice of Ms. O. The voice was needy and commanding. It invaded her consciousness and crushed her motivation, leaving her feeling lethargic and hopeless. The voice declared, "You are my possession." "You owe me your existence," it said. This refrain, that Ms. Sanchez was indebted to Ms. O for having given something essential for living, repeated itself throughout the psychotherapy. While she was furious at the voice, she also felt intense debt and obligation. It was as if the voice had granted her permission to exist, she said. Ms. Sanchez sometimes had the fantasy of pushing Ms. O through a window, or of strangling her.

In her psychotherapy, Ms. Sanchez focused on her relationship with her parents. They intruded on her life so much with their needs. Ms. Sanchez commented, "I've often thought that they need me to be weak and ill. They have a hold on me. I'm supposed to serve them. Maybe I keep this image of Ms. O close to me, like I keep them close to me." Dr. F commented that perhaps separating and letting them take care of themselves made Ms. Sanchez feel that she was abandoning them, or worse, killing them.

Ms. Sanchez went on to say, "I am crucial to their existence. They are both so lonely and nervous. They turn to me." Dr. F commented, "In this sense, you are their Saviour." Ms Sanchez was perplexed. Dr. F continued, "You feel an obligation to your grandmother and mother. You feel it's your job to rescue them from their unhappiness." Ms. Sanchez commented, "Yes, it makes sense. I feel like a prisoner. But I have a special role. Someone should give me an award."

The similarities between Ms. Sanchez' relation to her family and the voice of Ms. O were striking. Ms. Sanchez' conscience had a harsh and arbitrary quality, much like the voice of Ms. O. Dr. F linked Ms. Sanchez' fear of attack to her own angry feelings. Ms. Sanchez allowed herself to know her own rage only as a victim, she interpreted. Ms. Sanchez then wondered if the attack by Ms. O might be a punishment for her wish to separate from her family.

The relationship to God

At some point, Ms. Kelly, Mr. Singh and Ms. Sanchez developed an intense relationship with a hallucinated inner voice. Mostly, this relationship consisted of a speaker and an audience, in which the patient listened to the voice and received guidance and support from an inner authority. The inner figure was experienced as powerful and judgmental and it instructed the patient on "correct" behaviour. The inner figure issued commands and demanded obedience. The patient did not express his or her own opinions to the voice, nor did the voice reveal its own subjective experience, or give a first-person account of how or why it made its judgments. The exception to this was the voice of Ms. O. When Ms. Sanchez felt strong enough to defy Ms. O's orders, Ms. O expressed fear. "I will be annihilated if you and Dr. F keep this up," it said.

The hallucinated attachments I have described gave these patients a sense of purpose and direction. Each had experienced months if not years of feeling futile, impotent and scattered. The voices brought this formlessness to an end. The patients were directed to act in a particular way—and the hallmark of this action was its moral correctness. *Webster's Dictionary* defines morality as "conformity to the rule of right conduct". The hallucinated voices of these patients focused precisely on this point: how to behave correctly. The inner voice thus became a moral guidepost. The relationship with God or with God's emissaries revolved around how to act correctly.

Mr. Singh said that since he began to hear Krishna's voice, everything was now in order. "Living is a moral challenge. If you benefit the world, you will feel

serene," he said. At another point, he said, "I now have an ethical foundation, so I don't have to worry. I know what is right and wrong now. Doing good work makes my existence have a purpose."

Ms. Kelly and Ms. Sanchez' connection with God was not so comforting. Nevertheless, the commands of God or Ms. O were a core around which they organized their lives.

The inner voice seemed to serve several key functions:

First, it provided relief from an intolerable sense of loneliness. When the voice is mainly benign, this is not hard to understand. It provides an attachment, which is omnipotently controlled by the patient. Ms. Sanchez was particularly clear about how difficult this loneliness was to bear. It is also not difficult to imagine why a patient might create a relationship with a hallucinatory figure who is punishing. Masochistic object relationships can be experienced as very intimate. A tormenting connection is felt by many patients to be preferable to no connection at all. The voices that spoke to Ms. Kelly and Ms. Sanchez may have been painful, but they were steadfast in making personal contact with them. Ms. Sanchez said, "I wouldn't survive a minute without God." Mr. Singh said, "Now, I have an ally. Krishna is always by my side now. He is soothing." A nonpsychotic schizoid man, Mr. Warren, said that his inner voice (in this case, not hallucinated but metaphoric) was like a "security guard". It was harsh but also was "the most reliable friend I've ever had".

Second, the direction of a moral authority helped these confused and ambivalent patients figure out "what to do" in their lives. Many societies develop highly structured codes of conduct. Religious and political orthodoxy support such rules. From this viewpoint, morality is a system of behavioural do's and don'ts that sanction membership in the group. When the self is shattered and identity is diffuse as it often is in people with a diagnosis of schizophrenia, the sense of what to do and how to act becomes hopelessly obscure. There is a deep sense of feeling like an alien who does not comprehend the rules of membership in humanity. A strict code of conduct sanctioned by the highest authority not only gives coherence to one's thinking but also gives clear guidelines about how to avoid estrangement from the group. Orthodoxy ensures membership.

This is, I think, part of what Lacan refers to when he discusses the "Name of the Father". The symbolic order is anchored in social mores and encoded in language (i.e. the unconscious). It structures both individual thought and social relationships. In psychosis, the Name of the Father and the Symbolic Order are not installed in the person's mind. The individual feels alone in coming to terms with the terrifying existential questions of life—Who am I? What should I do? What do others want from me?—all on his own. This existential burden experienced in lonely isolation feels unbearable and can lead to desperate attempts at safety and protection including emotional withdrawal and sudden, invented, comforting, meanings (e.g. delusions). The pressure of these anxieties is put to rest by an undisputed authority linked to a world-organizing ideology. For most members of society, this kind of comforting authority is found in religious or

political doctrine, or in popular culture. This prescribes how to live and how to settle moral dilemmas. Members of the group are relieved of moral anxieties and are comforted by the embrace of fellow group members. In schizophrenia, a private, idiosyncratic and socially isolated orthodoxy can replace the conventional norms shared by members of the culture.

A third function that inner voices serve is boosting the person's self-esteem. The voice of a benign God is an omnipotent and idealized companion. It is all-powerful and most importantly it cares about the individual soul of the person who so often feels anonymous and impotent.

Mr. Singh basked in the special intimacy he had with Krishna. Even when the voices were demanding or threatening, the grandeur of the voice's authority conferred stature and significance to the patient's life.

Ms. Sanchez was criticized but at the same time she felt that she was key to Ms. O's and St. Teresa's plan to save the world.

Ms. Kelly was hounded, but by a God who had picked her for a historic mission.

Fourth, the relationship with the inner voice helps the person cope with their own frightening destructiveness. The relationship can be a profoundly masochistic one in which the person feels belittled and attacked.

In Ms. Sanchez' case, Ms. O ordered her to rid her life of all signs of her own individuality.

While Krishna was supportive of Mr. Singh, he aggressively demanded obedience in return. In this way, despite the appearance of masochistic submission, Mr. Singh's own aggression, now directed inward, seeped out.

When she was more psychotic, Ms. Sanchez wished to strangle her grandmother. She also fantasized about killing Ms. O, and throwing her broken body in a river. These overt expressions of hostility contrasted with her feeling weak and vulnerable to Ms. O. She experienced Ms. O as a moral terrorist. Ms. Sanchez was dimly aware that her own hatred might play a role in her feeling threatened and weak. She said, "The hatred within me is tearing me down." Sometimes, it seemed to Ms. Sanchez that her own hostility was trapped within her, and was eating away at her identity. Moreover, it appeared that the guilt connected with her hostility was holding her back from feeling more assertive and focused.

The meaning of being the Messiah

The belief that one is the Messiah has long been part of grandiose fantasies in people with psychosis. Of course, belief in a Messiah is an integral part of many religions. It is such a ubiquitous fantasy that it invites us to try to understand it from a psychological angle. I have observed in a previous paper (Lotterman, 2003) the fact that some neurotic patients in psychoanalysis feel a powerful form of pre-oedipal guilt connected to the feeling that they have not repaid a debt for having been created. At some point in their development, these patients felt that they owed their existence to their parents, and this stirred up a mixture of awe, gratitude and defiance. At some point the child becomes aware that without the

mother and father, he would not survive. As the child reflects on this, he wonders: what does this gift of life mean? His parents gave him life. What does he owe in return? If he has incurred a debt, how does he repay it? With such a moral debt, does the child dare to live his life for himself? Does he have the right to separate and live on his own? The potential to feel debt concerning the gift of life, I think, is universal.

This sense of debt is further complicated by the child's ongoing need to be taken care of. The need for care-taking obviously impinges on the parents' freedom to pursue their own individual wishes without limit. The child must be fed, clothed and held and all this requires time and energy. As the child sizes up his moral accounts, he considers the state of his parents' lives. Are they capable of joy, or do they seem unhappy and burdened? If a mother is reasonably content, she will communicate her pleasure in living to her child. In this case, the child concludes that here is no outsized obligation that he must repay. He may feel that his mere existence is joy enough to repay whatever debt he may have incurred.

However, if the mother is not happy, if she is chronically depressed or unfulfilled, the child will certainly notice. Not able to understand his mother's pain in its wider context, he may believe that it is the weight of his needs that have made her unhappy. In this case, he feels that he is a burden, causing her misery. He may feel guilty and come to feel guilt about being born. The most common reaction to this is some form of self-deprivation and masochism. The child may resolve to devote himself to the task of making the sad and damaged parent happy and whole again. This mission may last a lifetime. However, no matter how well intentioned the child may be, he does not have ultimate control in the end over whether his parent is happy or content. The parent may not be "cured" by the child's efforts at emotional rescue.

One ominous possibility is that the parent may encourage the child's belief that he has damaged him, and owes the parent some form of repayment. In essence the child is bound in a moral trap. A parent may impose such a burden in the interest of control or power or a need for attachment. The parent may be motivated to keep the child in a state of perpetual debt to hold him close and exploit his attachment. For his part, the child may come to believe that he will never be able to repay the parent for the gift of life. He feels stuck in an endless sacrifice of his own development and pleasure to rescue the parent from his misery. The child does not have the emotional perspective to judge that his loving efforts have been sufficient and that his parent's fate is not his responsibility.

I believe that debt concerning the gift of life and guilt about being born are constellations of fantasies and emotions that are elaborated in the Messiah delusions we see in people with psychosis. I will give some examples from the psychotherapies of the patients described above.

From earliest childhood, Ms. Kelly recalled that her parents were at odds. Her father was a remote and preoccupied man. Her mother was an anxious woman, who turned to her child as a confidante. Ms. Kelly felt caught in between. "They wouldn't like it if I felt better," she said. "They want me to continue to feel some

kind of ethical obligation." Ms. Kelly seemed to mix up the demands of the inner voice with her parents' needs. When asked why she wanted to be a Messiah, she answered, "Because I care for my mother and father, and I want to make them happy." When asked what she hoped to accomplish as Messiah, she responded, "It's honourable to forgo your life for the benefit of humanity", later adding, "It's the way I can do some good for my father." At one point, she came to believe, contrary to her earlier ideas, that her father wanted her to be the Messiah, because it would improve her father's self-esteem. "But," she added, "my mother—she's especially entitled to be compensated. She is the one who is entitled to be made whole. She's given so much."

Ms. Sanchez said that her parents sometimes acted so unhappy, so deprived. "I feel like they depend on me to be ill in some way," she said, adding, "because then they can attach themselves to me. It's like my existence is for them. My mother depends on me somehow. I can't explain it. She depends on me to be there for her emotionally. It's the same with the voice of Ms. O."

Over the course of her therapy, Ms. Sanchez worked with Dr. F on her wish to disentangle herself from her parents and pursue her own life goals. She had recently made some friends and was pleased that the warmth she felt for them seemed to make her feel alive and more whole. These developments alternated with feeling that she was stuck in a relationship with her dependent mother and her critical grandmother. "It frightens me to separate from them. I think that I am an essential person to them somehow. Their lives are so lonely. I think that they turn to me to fill a vacuum." In this context, Dr. F first mentioned the link between Ms. Sanchez' sense of duty to her family and her belief that she was being enlisted as the Messiah. Ms. Sanchez commented, "It's funny; I feel buried under obligation, but I also feel uniquely important."

Ms. Sanchez began to feel that having fun without excessive guilt might be possible. She also began to make tentative steps towards independence. She found a job and began to date. This gave her enormous pride and hope. She worried, however, that she would want to separate more and more from her grandmother and mother. She feared that because of her independence, they would collapse and break into pieces.

Ms. Sanchez' excitement about her new social connections brought on increasing attacks by Ms. O. Ms. Sanchez felt a debt to Ms. O for having helped her so much. She felt an ethical responsibility to carry out Ms. O's wishes because of this debt. Her gratitude for Ms. O's support alternated with fear and disgust when Ms. O was imperious, demanding and invasive. Ms. O insisted that she had given Ms. Sanchez life, and that Ms. Sanchez owed her obedience. Ms. Sanchez believed that Ms. O was jealous of her affection for others. She said that to be free to live her own life, maybe she had to kill off Ms. O. This thought, however, was terrifying. As with Ms. Kelly, it was difficult to distinguish between Ms. Sanchez' reactions to her family and to the hallucinated voice.

When Ms. Sanchez began to work full-time at an accounting firm, for example, she felt that both her grandmother and Ms. O disapproved. Over time,

Ms. Sanchez explicitly connected the relationship with Ms. O to her ties to her mother and grandmother. At one point Ms. O commanded, "Obey your grandmother", and even claimed to speak for her. The patient and her therapist discussed her struggle to separate from her family, and the fear and guilt this stirred up.

I want to conclude this section by emphasizing two points. First, the patients I have described were all struggling to establish a coherent identity, separate from their families. They believed that their parents were hostile to their wishes to stand on their own. The voices they heard embodied a struggle over separation and individuation. The voices of Ms. Kelly and Ms. Sanchez accused the patients of a moral crime: the crime of ingratitude. They were afraid to violate the first biblical commandment: honour thy father and thy mother. These patients believed that if they followed their natural urge to grow to be separate and strong, and to crystallize an identity, their parents would suffer. They believed their parents to be fragile, and because they felt they owed a primal debt, the wish to leave home was connected to intense guilt.

The punishing voices they heard embodied both the parental prohibition against separation and their own rage about being stifled—a rage that was now displaced upon themselves. Ms. Sanchez explicitly wondered if she had to murder Ms. O to finally be free, and I think each of these patients wondered if they had to kill off their own parents to finally grow up. Hans Loewald (1979) discussed a similar conflict connected to the Oedipus complex. He believed that to become a self worthy of the name, one must kill off the parents as the final moral authority. In the end, one must become one's own moral authority. I believe these psychotic patients struggled with their guilty wish to leave their parents, which they experienced concretely to be a parricide. They were faced with a moral dilemma: if I live and thrive, my parents will die. Their persecutory voices embodied their own self-punishment for these wishes. Part of their functional disorganization may also have been an attempt to undermine their abilities to function separately.

Second, for many people, the key to successful separation lies in the ability to feel love. The experience of affection for another person enables a person to experience himself as real and coherent. It gives a feeling of value and goodness, and softens guilt and self-attack. The experience of loving helps consolidate a person's sense of having a potent and viable self. It helps reverse the experience of being shattered into bits and fragments. The coherence of the self as a functioning unit depends in part on confidence that one's love is good. Accusatory voices attack this belief. They make it difficult for the person to feel that he has something of value to offer others, and so undercuts the hope that he can find emotional partners in the outside world. In the end, in order to get, one must give. Such voices discourage the person from trying to enter the wider world by making him feel hopeless about the value of his love, and making him doubt that others would want to return love and care in exchange for it.

In this, the voices may mirror the person's experience in their own family, in which they often felt mocked and criticized. A powerful way to bind a child to the family is to undermine his belief that he has something to give to those

in the outside world. The courage to separate is based on the belief that one is lovable and that one's love will be wanted by others. This is the currency that is exchanged by people outside the family. If the child does not believe in the value of his love, he will not believe that others will exchange friendship and help in return for it, and he may never attempt to leave the family. He will be trapped. The conflicts about debt concerning the gift of life, and guilt about being born, may affect the child's confidence in his own goodness, and in his right and his ability to separate from his parents. Instead, he may stay at home, striving to rescue his parents from their misery. The result may be a grandiose and developmentally disastrous mission to become a Messiah to his parents.

Note

1 The experience of some people who are not manifestly psychotic can be similar to those who are more clearly psychotic (e.g. Mr. Tilden's end-of-the-world fantasies and disrupted thinking, and Mr. Green's profound schizoid isolation and "autism"). I think many "psychosis-like" experiences that occur in severe character disorders have something in common with more overtly psychotic states. One may think of them as "forme fruste" (incomplete phenotypic expressions of) versions of psychosis, albeit less intense and dramatic.

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10

COMPARISON WITH OTHER TECHNIQUES

I would like to compare the psychotherapy techniques I have outlined in this book with some of the best known approaches to the psychotherapy of patients diagnosed with schizophrenia. This will explain why I think they are particularly suited to work with patients who have a psychotic structure.

Ego psychology

Mainstream ego psychology followed Freud's lead in avoiding the use of psychoanalytic techniques with patients diagnosed with schizophrenia. Among Freud's objections to psychoanalytic work with psychotic patients was his belief that they were not able to establish the transference upon which psychoanalytic work depended. He wrote, "Observation shows that sufferers from narcissistic neuroses have no capacity for transference or only insufficient residues of it. They reject the doctor, not with hostility but with indifference. For that reason they cannot be influenced by him either; what he says leaves them cold, makes no impression on them; consequently the mechanism of cure which we carry through with other people cannot be operated with them" (1916–17: 447).

Paul Federn (1934, 1943a, b, c, 1952) was a notable exception to the general pessimism concerning work with such patients diagnosed with schizophrenia. He used psychoanalytic techniques in his work with psychotic patients, albeit in a modified and limited way. Federn emphasized the importance of helping the patient maintain a positive transference. His goal was to encapsulate the psychosis and strengthen the nonpsychotic part of the patient's personality. To accomplish this, he advocated abandoning the following: free association, analysis of the positive transference and analysis of resistance and defence. He also advocated suspending the treatment if the negative transference grew too intense. In emphasizing supportive techniques, his approach was similar to that of Lacan (1955–56, 1959).

Later on, Arlow and Brenner (1964, 1969) argued that neurosis and psychosis exist on a continuum, and that the symptoms of psychosis no less than those of neurosis arise as a result of conflict, defence and compromise formation. They presented a theory of psychotic psychopathology in which symptoms served

as defences against intense anxiety and guilt. In their view, one of the unique features of psychosis is that there is a regression in the functioning of the ego in the service of defence. In particular, defensive modifications of the ego's capacity to integrate mental contents and use language impair the functioning of the psychotic patient. They advocated the use of interpretation to ameliorate the effects of this ego regression.

Boyer and Giovacchini (1967, 1980) claimed to have treated psychotic patients with the use of unmodified psychoanalysis. They recommended the use of the couch and free association. They believed that the treatment falls into two phases. In the first, or "noisy phase", the goal is to replace cold, hostile internal objects with warm, loving ones. This is done by making contact with the patient through verbal interpretation, and by maintaining a hopeful, optimistic, detached attitude. In the noisy phase the patient's distortions, contradictions and abandonments of reality are gently confronted. The defensive function of their use of psychotic thinking is interpreted and there is a focus on aggression. A second, quieter phase of treatment follows in which a transference neurosis is established and interpreted.

Boyer and Giovachini believed that there is a striving in the psychotic patient toward ego maturation, and that working through the regressive psychotic transference reduces conflict and enables the maturing of conflict-free aspects of ego functioning. They emphasized the importance of interpretation as a method both for making contact with the patient and effecting a revision of faulty ego and superego structures.

Sullivan and his followers

An important approach to the psychotherapy of psychotic patients was begun by H. S. Sullivan (1940, 1953, 1962, 1964). He believed that patients diagnosed with schizophrenia do, in fact, establish transferences, even if they are often intense and unstable. He described what he called the "one genus hypothesis" (1953: 32–33), which emphasized that persons diagnosed with schizophrenia are more like other human beings than they are different. He emphasized that the symptoms of schizophrenia resulted from the patient's flight from anxiety and his need for security. Sullivan emphasized the importance of establishing contact with patients, and the need to approach the often frightened and traumatized person with respect, tolerance and acceptance. In an effort to make such contact, departures from traditional analytic neutrality and detachment were often necessary. The therapist functioned as a "participant observer". The therapist might, for example, communicate his own feelings to the patient if that helped to make a human connection. It was essential to be honest in one's interactions with the patient.

Frieda Fromm-Reichmann (1959) followed Sullivan's lead in emphasizing the importance of the patient-therapist relationship. She emphasized the patient's defensive escape from pain, conflict and anxiety. At first, she believed that the psychotic patient suffered from powerful narcissistic injuries and that it was

essential that the therapist help foster a positive relationship. Later, she came to feel that one must not ignore the patient's aggression, and must address it in the psychotherapy. She felt that if the therapist tries to discourage the expression of aggression, as Federn did, the patient will conclude that the therapist is afraid of his own or the patient's hostility.

Working within this tradition, Elvin Semrad (Semrad et al., 1952; Semrad, 1966) believed that psychotic symptoms represented maladaptive behaviour. He saw therapy as a "corrective ego experience" in which the therapist might have to be "gratifying, rewarding and growth stimulating" to help the person diagnosed with schizophrenia. He wrote that therapeutic interventions might involve "gratifying needs, and providing sustenance, support and security, as long as the study of the patient's flight is in process" (1966: 159). Semrad believed that the basis of the patient's symptoms was a flight from unpleasure which overwhelmed the ego, and led to a "body response to disintegration, terror, fear, panic and dread". He emphasized that the treatment was an intimate experience in which the therapist needed to feel many of the painful affects from which the patient was trying to escape. The essential work of the treatment was to help the patient to "acknowledge, bear and keep in perspective" (1966: 157) painful affects and life experiences, often connected to loss. The therapist needed to help the patient "stop, look, listen, and stop running". The patient's developing ability to tolerate such affects and to put them into words was the bedrock of his improvement.

Klein and her followers

Another significant approach to the psychotherapy of patients diagnosed with schizophrenia was initiated by Melanie Klein (1923, 1930, 1935, 1946, 1957). Klein described two principal emotional "positions" in early childhood to which adult psychotic patients regressed: the paranoid-schizoid position and the depressive position. The paranoid-schizoid position was characterized by anxieties about physical and emotional attack, cycles of projected and introjected aggression, fantasies of the self splitting into fragments, entering others and being subsequently re-introjected, and object relations characterized by part objects. Part objects were understood to be representations of the self and others in which parts of the physical or emotional self are split off or isolated from other parts of the personality. An image of an exclusively "good" mother who is uncontaminated by fantasies about the "bad" aspects of the mother is an example. In the depressive position, the affects of hate and love are brought together and result in the capacity for guilt and concern. Guilt springs from anxiety about the harm that one's aggression can bring to those whom one loves. The capacity to integrate love and aggression ushers in the possibility of whole object relations in which self and object representations are characterized by both "good" and "bad" aspects.

The relations between the paranoid-schizoid position and the depressive are complex. The achievement of the depressive position signals not only a maturational step, but also a method of resolving paranoid anxieties by establishing

more loving and constant object relations that can withstand the onslaught of aggression. At the same time, if depressive anxieties become overwhelming, there may be a defensive regression to the paranoid-schizoid position as a defence against guilt.

Hanna Segal (1950) was one of the first within the Kleinian tradition to write specifically about psychotherapy with patients diagnosed with schizophrenia. She emphasized the role of splitting and denial as well as introjective and projective mechanisms in psychopathology. She said that in psychosis, unlike neurosis, a great deal of primitive fantasy was conscious, but that the links between fantasies and the links between fantasy and reality were treated as concrete realities because of the breakdown in symbol formation.

Segal applied Kleinian principles of interpretation to patients diagnosed with schizophrenia, and felt that it was important to "interpret the unconscious material at the level of the greatest anxiety, much as I would do with a neurotic" (1950: 113). In practice, for the early Kleinian analysts working with psychotic patients, this often meant identifying intense anxiety related to primitive body-related fantasies. These early Kleinian analysts believed that these fantasies involve projection and introjection of bodily contents such as faeces, urine and semen, or such mental contents as ideas and emotions.

These primitive mental contents are sometimes felt to be concretely evacuated into another person, controlling him from the inside via projective identification. Parts of the physical, emotional or mental self are thereby lost, and the psychotic person feels emptied and barren. There may also be fantasies (experienced concretely) of attack by the other, in which these often "bad" parts of the self are violently forced back. Primitive anxieties include the fear of falling into bits, and being driven crazy by the attempts of the other to force his bad aspects into the patient. The role of the analyst is to make these primitive and rather complex fantasies conscious by interpretation. In doing this, the patient would experience them as mental experiences, capable of being contained and managed (at first in the therapist's mind).

Segal gives an example of an interpretation made to a man diagnosed with schizophrenia who had auditory hallucinations and had started to practise eye exercises.

> Then I made a more complete interpretation. I reminded him of the death of his two relatives, his identification with them, his refusal to mourn them, and the triumph over them during the weekend. I suggested that, in performing eye exercises, he was watching the intercourse between his parents, and that he was killing the father or both parents, presented by the two relatives, by magic looking and magic counting. Finally he introjected the dead and triumphed over them. But apparently, they were not defeated; they came back to life inside him and mocked him, mocked particularly his magic looking and counting—the means by which, he thought, he had secured his triumph.
>
> (1950: 107–108)

It is difficult for the reader to make a judgment about how well this formulation is supported by the previous clinical material, and to what degree it represents a kind of interpretive summary of what had already been explored. Segal does not go into detail about this.

I provide this example for several reasons. First, it represents an example of the way early Kleinian authors formulated symptoms in their own minds—the roles of the depressive and paranoid positions, the use of manic defences, the central roles of introjection and projection and the functioning of internalized object relations. Second, it captures a particular style of interpretation, at least as it is reported by the early Kleinians. On balance, the examples they give of their work may not capture the gradual accumulation of clinical data that culminates in such dramatic interpretations. Interpretations seem to begin at the deepest levels (the "point of maximum anxiety"), and include references to very primitive fantasies in which the self and other are represented by body parts or functions.

For the modern reader, such examples, as reported, may seem surprising and puzzling. I give my own reaction to this style of interpretation later in the chapter. But there is great value in the way that early Kleinian clinicians tried to explore the extremely complex psychology of psychosis that is inherently bizarre and difficult to empathize with for the nonpsychotic mind. The value of interpreting the deepest layers first will be discussed later on.

Segal also emphasized the disruption of symbolic thinking in people diagnosed with schizophrenia and its role in such symptoms as concrete thinking and disturbed language use.

Rosenfeld (1952, 1954, 1965, 1969, 1987) also used Kleinian concepts in his work with psychotic patients. He emphasized the importance of paying "minute attention to the patient's communications" (1987: 4). Like Segal, he advocated interpreting the patient's "most prominent immediate anxiety" (1987: 40). Rosenfeld emphasized the central importance of the countertransference as a guide to the patient's inner state. Using projective identification, rather than verbal symbols, the patient diagnosed with schizophrenia conveys information to the therapist about his inner states. At times, feelings stirred up in the therapist may provide the only clues to what is going on in the patient. Like Segal, Rosenfeld reported the use of complex interpretations that identified intense anxieties and primitive fantasies.

Also like Segal, Rosenfeld emphasized the loss of symbol use in schizophrenia. He connected disturbed symbol use to "excessive projective identification (with its massive creation of objects fused with the self) [which] interferes with symbolization and verbal thinking . . . " (1987: 229). Rosenfeld stressed the importance of interpreting projective identification and splitting in order to preserve verbal thinking. However, as intriguing as these links are between the loss of symbol use and these primitive defences, Rosenfeld only alluded to the mechanism by which they may be connected. He did not give an explicit account.

More recent Kleinian writers such as John Steiner (1993), Betty Joseph (1997) and Ronald Britton (1997) have seemed to pay greater attention to interpreting

material that is located near the psychic surface, rather than material located at the point of "maximum anxiety". They are mindful of whether the affects and fantasies that are the object of interpretation can be tolerated by the patient. There also seems to be less emphasis by contemporary Kleinians on body organs as symbols of psychological experience. There is, however, continued emphasis on the importance of projective identification and on the analyst's emotional experience as a marker of what is happening inside the patient.

Thomas Ogden (1982) has also written from the perspective of Kleinian theory. He emphasized the central role of projective identification as a primitive form of communication by the patient. The therapist must be open to the fact that affects and fantasies stirred up by the patient offer clues to his inner life. Ogden described various stages in the therapeutic work with psychotic patients in which the patient first makes use of projective identification, and only later verbal symbols to communicate his thoughts and feelings.

Jacques Lacan

It is difficult to summarize the work of Jacques Lacan, and impossible to summarize it briefly. Nevertheless, I will try to describe some points of comparison between Lacan's view or views of psychosis and my own.

Lacan's ideas about psychosis evolved from his early writings in the 1920s and 1930s to his work in the late 1970s. Lacan's way of organizing mental life is unique and a challenge to understand. This challenge is further complicated by the fact that his view about many fundamental psychological processes changed significantly over the course of his career. This description of his work represents just a sketch of some of his more familiar ideas.

In the early part of his career, Lacan focused on the psychologically organizing effect that participating in a common language confers on the mind. A socially shared language structures the mind in profound ways. It establishes categories for representation and thought, both intrapsychically and interpersonally, and, according to Lacan, it enforces a separation between the young child and the tactile-sensory and boundary-porous participation with the mother. The crucial step of separation and individuation out of the compelling world-of-two with the mother must be reinforced by the intrusion of a third party into the relationship. On different levels of concrete experience, this intrusion may be made by the personal father or by the regulating function of a broader cultural authority (i.e. social convention).

The process of separation between mother and child has also been a focus of other psychoanalytic writers such as Mahler, Loewald (1978), Winnicott and Stern. For Lacan, this separation is supported by the force of culture which, in part, takes the form of the commonly shared language. In addition to language, childhood development enforces the gradual separation of the child from his early tactile participation with the mother and her body and substitutes for it relations with other people, and relations with the rules and practices of the culture

at large. Language plays a powerful role in this process and it is via language that categories of thought and social norms are introduced into the child's mind. Lacan referred to these cultural forces metaphorically as "the Name of the Father".

Now, according to Lacan, every human being must cope with certain very basic mysteries of existence. These are questions that lie at the foundation of subjective experience: who am I? What does my loved one want from me? What does my life mean in the face of death? What connects me to other people in love? These questions are profound and disturbing and cannot be avoided (they probably inspire many of the culture's great works which try to address them via religious systems, political ideologies and various other "isms"). As children grow, these pressing existential mysteries are addressed by the rules, rationales and dogma of the common culture. While often constricting, these cultural norms provide the child with "answers" that make him part of a broader culture and that remove the isolation and distress of having to confront these questions on his own.

In psychosis, access to the common culture that is made possible by language is blocked—"foreclosed" ("verwerfung") in Lacan's language. Conventional answers to life's basic enigmas cannot be made use of. The individual is cut off not only from these specific answers but also from the "common sense" of shared viewpoints and values used by other members of the culture. As a result of his cultural and linguistic isolation, his capacity to "mentalize" the inner lives of others is impaired. His capacity to empathize with others and to experience membership in the human community is constricted. He feels deeply alone—terrifyingly beset with all kinds of profound life questions for which he has no answer. He has no one with whom to share his burden. He is befuddled about the motives and actions of others and unable to share what Dan Stern (1985) calls "interpersonal communion". He is forced, so to speak, to "improvise" his own personal Weltanschauung to replace the common answers that reassure cultural group members. These improvisations emerge in the form of delusions, paranoid ideas and idiosyncratically coded forms of speech. He is not a co-author with the culture; he stands outside it. He is unable to experience the soothing and anchoring feeling of knowing and being known by other subjects. "The so called schizophrenic is specified by gaining no support by any established discourse" (Lacan, 1973: 474).

Beyond this, the psychotic individual's subjective experience has no access to a common symbolic language (the Symbolic) and it falls to perception and sensation to record and represent it. Mental experience is not viewed as coming from within (e.g. "the back of my mind"). Vanheule (2011: 67) puts it this way, quoting Lacan: "The theme of castration 're-emerges in the real' (Lacan, 1955–56: 13) via a hallucination. What is unable to be expressed in ordinary language (the Symbolic) returns to awareness via the concrete experience of sensation and perception (the Real)." Vanheule continues, "Elements from the unconscious are not experienced as coming from within—as in neurosis, where symptoms express warded-off truths—but as strange messages that come from without" (2011: 71).

In psychosis, thinking is thus replaced by revelation via perception. There is little room to experience something as a mental event that can be compared with other

mental events (in terms of its reality or meaning). Rather, it is a near-perceptual reality that reflexively elicits a concrete response. To say this differently: there is little or no "mind's eye" where mental representations are understood to be representations only. Moreover, "Due to the absence of Bejahung (that is, due to the presence of foreclosure), themes of the subject's existence do not enter into the law of the Symbolic, but emerge in the Real as puzzling and overwhelming problems that seize the subject from the outside" (Vanheule, 2011: 71).

This is what Lacan means by his statement that what is refused in the symbolic order re-emerges in the real (Lacan, 1955–56: 13), and in his suggestion that in psychosis "the nonsymbolized reappears in the real" (Lacan, 1955–56: 86) Later in his career, Lacan speculated that certain unusual individuals (James Joyce being one) might be able to compensate for the absence of the Name of the Father by creating their own unique way of structuring reality—the Synthrome. These individuals can bypass being installed in the social order by creating a unique place for themselves as accepted members of the culture. In Joyce's case, this acceptance was won by virtue of his special artistic ability. Joyce's idiosyncratic subjectivity was accepted by others because he was so valued. In this way, despite his incomplete enculturation into the Symbolic, Joyce was able to avoid the extreme social alienation of psychosis by virtue of the fact that his unique persona had itself become a part of the culture.

Lacan does not provide many concrete guidelines in terms of psychotherapy technique. Broadly speaking, though, for Lacan, the need of the person in a psychotic state is not to disentangle himself from conventional meanings as it is for the neurotic person, but rather to establish an organizing set of meanings to begin with. This means that the goal of treatment is to provide a personally organizing construction of reality that can compensate for the absence of the symbolic order. This may involve various supportive measures to help the patient establish a functional set of interpretations of reality within which he can function.

Some American contributions

The following describes the work of some American clinicians. Recent approaches from other parts of the world have been outlined in *Psychotherapeutic Approaches to the Schizophrenic Psychoses* (Alanen et al., 2009). This book is part of a series of works sponsored by the International Society for the Psychological and Social Approach to Psychosis.

Eric Marcus' *Psychosis and Near Psychosis* (1992) outlines an ego psychological approach to the psychotherapy of psychotic states. Marcus understands psychotic experience to be a condensation of perception and emotion. What begins as an affective experience is transformed into a perceptual one (a "thing presentation".) Marcus goes on to describe the ways in which ego functions are impaired in psychosis ("psychotic structure") and the effect of these impairments on people's perceptions and emotions. One of the cardinal problems in psychosis is the use of dissociation (e.g. primitive denial) in keeping emotionally painful experience out

of integrated conscious awareness. Affects that cannot be symbolized return in the form of percepts. Marcus goes on to recommend techniques that help to reduce vertical dissociation and help the patient to be aware of the emotional basis for disturbing thing presentations.

In 1995, David Garfield published *Unbearable Affect: A Guide to the Psychotherapy of Psychosis*. The central premise of the book is that psychotic patients experience unbearable affects and their symptoms and mode of living are attempts to protect themselves from tormenting emotions. Garfield bases his approach on that of Semrad, who advised that psychotherapists help patients in "acknowledging, bearing and putting in perspective" their painful feeling states (Semrad and Van Buskirk, 1969). Semrad emphasized the centrality of painful emotions, their representation in the body and the therapeutic importance of bearing these emotions. Garfield, like Semrad, emphasized that unwanted affect may be experienced in the form of body experiences and sensations.

The therapist's task is to listen for affect and determine the "dominant affective category". This is often revealed by "non verbal components such as grooming, style and color of dress, gait, gesture and manner . . . ". Often the main emotional theme becomes woven into the daily events that precipitate psychosis. Unbearable affects are the engines behind the formation of psychotic symptoms. Garfield, like many other authors, places great emphasis on countertransference as a means of making contact with the patient's subjective inner life. He also uses Daniel Stern's ideas about "vitality affects" to develop ways of mirroring patients' behaviours in order to establish intersubjective contact.

The difference between Marcus' work and Garfield's is one of emphasis. Marcus focuses on the dysfunction of the ego, and his technique addresses the various ways that ego functions can be improved. The management of affect is just one of these functions. Garfield's emphasis is on the ego-disrupting impact of unbearable affect. His focus is on helping the patient bear the full weight of these disruptive emotions.

Major themes in psychodynamic approaches to psychosis

In looking back on the work of psychodynamic writers, one is struck by many areas of agreement. Many authors emphasize the patient's inability to tolerate intense affects and the way in which these affects become incorporated into bizarre perceptions and sensations. Most authors underscore the importance of countertransference in containing and experiencing affects that have been denied by the patient. Many writers also stress the importance of translating distorted perceptual experience back into the emotions and fantasies from which they sprang.

At the same time, it is difficult to evaluate the work of some psychoanalytic writers because their clinical summaries do not include details of how they diagnosed their patients. It is not clear therefore whether the patients they write about

have severe personality disorders with brief psychotic experiences, affective disorders or schizophrenia. As a result, it is difficult to gauge the effectiveness of their technical suggestions with patients diagnosed with schizophrenia. It is important to keep in mind that these diagnostic categories are neither distinct nor well defined. The boundaries between the diagnostic categories listed above may be quite fluid.

Cognitive behavioural therapy

The use of cognitive behavioural therapy (CBT) with psychotic patients first began in 1952 when Aaron Beck worked with a patient who had psychotic symptoms (Beck, 1952). After extensive use for anxiety disorders and depression, clinicians began to use CBT with patients who had psychotic symptoms in the late 1980s and early 1990s. Various studies have reported that using CBT helps reduce psychotic symptoms (Khan et al., 2001; Sensky et al., 2000), including positive symptoms (Zimmerman, 2005; Turkington, 2006) and negative symptoms (Sensky et al., 2000; Rector and Beck, 2001; Tarrier et al., 1993). It has also been reported to help reduce the chance of relapse into psychosis (Gumley et al., 2003). Studies with PET scanning have demonstrated that CBT is associated with changes in cortical and limbic pathways (Goldapple et al., 2004). Morrison et al. (2014) provide preliminary evidence of the possible usefulness of CBT with patients who are not taking medication. The National Collaborating Centre for Mental Health recommended the use of CBT with psychotic patients (NICE, 2014). There is some controversy about how much the effects of CBT are nonspecific and due to the general support the treatment offers.

The essential CBT approach to schizophrenia involves modifying core psychotic beliefs (cognitions), building coping skills (for symptoms and for social interaction) and normalizing and de-stigmatizing psychotic experiences such as visual and auditory hallucinations and paranoid ideas. These tasks are achieved by identifying alternative explanations for psychotic experiences, examining evidence and dysfunctions in logical inference made by patients and educating patients about the fact that many normal people experience unusual sensory experiences and increased suspicion at various times.

Psychotic experiences are understood to result from personalizing experience (e.g. ideas of reference), magnifying or minimizing the significance of events (e.g. delusions or denial), overgeneralizing and all-or-none thinking. CBT depends on the existence of a nonpsychotic portion of the patient's self or ego that can make an alliance with the therapist, and that has the capacity to step back from experience and examine it. This capacity calls upon the patient to keep an open mind, be curious about his subjective states, be motivated to seek out a realistic account of events and cooperate and collaborate with another person. The patient must enter the treatment with a wish to discuss his symptoms, a willingness to tolerate distress, a desire for change and some degree of hopefulness.

The relationship with the therapist is cooperative and collaborative, and in general, this relationship must exist in a realm outside the domain of the psychosis. CBT depends on a working alliance not overly disturbed by the patient's psychosis (e.g. not distorted by a paranoid transference).

Wright et al. (2009: 47–48) acknowledge that severe forms of mental illness may not be suitable for CBT. When the alliance is distorted by suspiciousness, hostility, hopelessness, social withdrawal and pre-existing relationship difficulties, CBT becomes much more difficult. CBT depends on a cooperative didactic format in which the clinician is helping or teaching the patient about new ways to view and adapt to reality.

CBT aims to identify core beliefs that lead the patient to distort his perception of reality. These core beliefs are similar in many ways to the "fantasies" that psychoanalysts try to identify in working with patients. Clark (Clark et al., 1999), for example, wrote, "In talking with patients about their childhood and adolescence, it is important to attempt to identify core beliefs (schemas) that may be related to illness expression. Beliefs that are laid down in this period of life can play an influential role in psychiatric illnesses because they direct patients' appraisal of situations and their patterns of automatic thoughts and behavior."

Key beliefs or schemas are thought to be more distorted in schizophrenia than in nonpsychotic conditions. Wright et al. acknowledge that this form of psychotherapy involves an uncovering of unusual associations that may not be familiar to many CBT practitioners. They write, "The therapist attempts to uncover how thoughts were linked to specific triggers and how these come together to form strong, seemingly unshakeable beliefs. Because most clinicians have not attempted to perform this sort of analysis before learning CBT methods for psychosis, the process of trying to understand and formulate associations between psychosocial influences and the development of psychotic symptoms may seem alien at first" (2009: 100). Implicitly, the authors acknowledge the need for some "psychodynamic-like" methods in work with psychotic patients.

One possible limitation of CBT is that it depends on a didactic method that requires the patient's pre-existing capacity to form a therapeutic alliance. Many patients diagnosed with schizophrenia are mistrustful and unmotivated to cooperate with a mental health professional, and they often deny that their problems originate in themselves (and thus do not need "therapy"). Historically, problems of "resistance" to therapy have not been a focus for CBT researchers. Within the CBT literature, resistance in general has not been a focus of the therapeutic approach. Recently, however, this has begun to change somewhat, and CBT practitioners have started to acknowledge the importance of understanding and addressing the patient's covert opposition to treatment (Castonguay et al., 1996; Leahy, 2003; Westra, 2004; Ledley et al., 2010). In contrast, as a matter of course, psychodynamic psychotherapy recognizes the understanding and addressing of resistance as an essential part of its work. It is understood that opposing the work of the treatment represents a compromise between the patient's wish to be healthy and to protect himself from danger and pain, by maintaining the status quo of his symptoms.

Another possible limitation of CBT is the assumption that emotions are essentially post-cognitive—that is, emotions basically follow from cognitive appraisals. In theory, it is the cognitive idea that the patient has about his circumstances that directs which emotions will occur. Emotions may feed back to influence how cognitions are developed, but this is a secondary phenomenon. There is some truth to this formulation, but from a psychodynamic standpoint, emotions are a primary and core experience. Affects are essential signals that reflect that existential status of the self to oneself and to others, often via nonverbal behaviours. They are an "adaptive form of information-processing and action readiness that orients people to their environment and promotes their well being" (Greenberg, 2004).[1]

Affects represent the core motivational and appraisal aspects of the self and are markers of what is most importantly on the person's mind (Lotterman, 2012). Emotion often precedes cognition and processes information on a distinct and separate level of function from thinking. The seat of basic emotions are midbrain structures such as the amygdala whose task (in part) is to provide a rapid response evaluation of the environment to facilitate survival and adaptation. These responses are not easily influenced by the cognitive and intellectual operations of cortical centres. Powerful emotions often precede and lie underneath the cognitions that are the focus of CBT. They influence experience from "the bottom up" (from more primitive body-based functions, e.g. the amygdala) rather than from "the top down" (e.g. the cortex), as cognitions do. Many of the aspects of CBT treatment of psychosis are covered more comprehensively in the book *CBT for Psychosis* (Hagen et al., 2010).

Despite the differences in theory, there are substantial areas of overlap between CBT and psychodynamic approaches. Traditional behaviour therapy requires that the patient face his automatic anxiety response of avoidance. Exposure and response prevention require that the patient face his fear long enough for that fear to extinguish in absence of the expected catastrophic event. Similarly, psychodynamic psychotherapy calls on the patient to "stop, look and listen" to his affects long enough to identify what these crucial affects are.

There are at least two benefits to this approach. First, powerful emotions and fantasies elicit powerful and primitive defences (projection, denial, perceptualization, etc.), which lead to symptoms. If the affects that are defended against can be tolerated consciously, the need for symptom formation is diminished. Second, the process of facing one's fears helps the patient to build "ego strength" by building up the adaptive and realistic functions of the ego via a kind of "affect strength training". The growing ego strength of the patient, and his perception that he has such strength, helps to mitigate the profound demoralization that insidiously devastates the patient's sense of agency and hope. Psychodynamic therapy is similar to exposure and response prevention therapy in introducing the patient to a graded series of exposures to powerful affects. In each form of therapy, the patient is asked to take a small, tolerable step in bearing anxiety and fear. Having mastered a particular step, the patient is ready to take the next. If the process is gradual, the patient gains the freedom to experience his emotional life more fully, to build up

his functional capacities and to experience himself as increasingly courageous and strong.

Several psychodynamic approaches to patients diagnosed with schizophrenia emphasize the primary importance of emotion. The approach of Garfield and myself makes the exploration of affect central. From my point of view, the identification and elaboration of affect mobilize experiences that are deeply encoded in midbrain emotional structures and expose them to new learning experiences. The treatment of symptoms by correcting logical cortical processes, as is emphasized in CBT, may not reach these deeper layers.[2]

Acceptance and commitment therapy

In the last fifteen years, another approach to psychotherapy with psychotic patients has been developed. The focus of medication and CBT has been on the elimination or control of symptoms. Acceptance and commitment therapy (ACT) (Hayes et al., 1999) challenges this focus. Goff (2002) found that the presence of symptoms itself is not necessarily distressing to some people and most people are able to avoid hospitalization despite having psychotic symptoms (Bustillo et al., 2001; Van Os, 2009). ACT maintains that a focus on symptoms can exacerbate the patient's self-preoccupation, inward focus and social withdrawal. It also maintains that a crucial problem in psychosis has to do with the individual's relationship to their symptoms. People may act out, for example, to cope with and defend against bizarre psychotic phenomena.

Some data suggest that attempts to eliminate psychotic symptoms may actually make them worse. Several studies (e.g. Morrison, 1994; Morrison et al., 1995) linked patients' efforts to avoid thinking about psychotic experiences to increased symptomatology. ACT attempts to alter the relationship the patient has with his symptoms by changing the patient's conviction about the reality of his symptoms and their behavioural effects. ACT seeks to help the individual to treat a psychotic event as a psychological experience rather than as a fact, to understand and accept the emotions that go along with it, and to pursue meaningful life behaviours and plans despite the presence of psychotic experiences. ACT stresses the importance of "dropping [a] needless control agenda" (Pankey et al., 2003: 318) in relation to symptoms, and emphasizes maintaining adaptive function despite bizarre perceptual, cognitive or affective experiences.

The patient is asked to "sit with" the psychotic experience while in the presence of the therapist. Patients are asked to "defuse" themselves from the literal perceptions or beliefs of their psychosis, to step back and to consider what they feel as an experience per se. There is some evidence that this approach is helpful in practice (Bach and Hayes, 2002). The methods of ACT overlap to some degree with those of CBT and psychodynamic therapy. They share with CBT the effort to desensitize the patient to psychotic experiences, to normalize them and to avoid thinking of them as catastrophes. They are similar to

psychodynamic therapy in that they ask the patient to "stop, look and listen" to their psychotic experiences and their affects and to be curious about their quality and nature.

Comparison with my own work

Having summarized some of the main approaches to psychological work with psychotic patients, I would like now to make a few brief comments about how the techniques presented in this book resemble and differ from those described above.

In general, I agree with much of the emphasis of other psychodynamic writers. As noted above, many psychoanalytic writers emphasize the difficulty psychotic patients have in tolerating intense affects. They also agree that countertransference experience is a crucial channel of information about the emotions of the patient. Many emphasize the way in which emotion and thinking become transformed into perceptions that have a bizarre and uncanny quality. With all these points, I agree. On the other hand, there are relatively few writers who attempt to describe the particular way the mind is structured in psychosis and to base their treatment approach on it. Lacan and Marcus make attempts to do this, as do I. I differ from Lacan in his conclusion that foreclosure precludes intensive psychological exploration. I agree with Marcus that the particular psychological structure in some people diagnosed with psychosis requires an approach that is tailored to that structure.

I will outline more specific points of agreement and disagreement below.

My own approach is similar to that of the more classical psychoanalytic theorists in that it emphasizes the defensive nature of many psychotic phenomena. It relies on clarification, confrontation and interpretation of the patient's material. I believe that the interpretation of conflict can ameliorate at least some aspects of psychopathology associated with "schizophrenia".

My approach differs in that I do not believe that neurosis and psychosis occupy a continuum, differentiated only by degree or intensity. I think that the psychological structure of people diagnosed with schizophrenia differs fundamentally from that of neurosis. The functions of the ego, in particular symbol use, in people who are psychotic are profoundly different from those in neurosis. Because psychotherapy is such an exquisitely verbal event, one must first address distortions of symbol use before one can undertake a standard verbal treatment. Many authors within the traditional psychoanalytic tradition do not seem to address this problem.

My approach draws a great deal from that of Sullivan and his followers. Their emphasis on the importance of the therapist-patient relationship, especially the importance of treating the patient as a respected colleague in the therapeutic work, is very valuable. I agree with Semrad (1966), Searles (1962, 1963, 1965, 1971, 1972) and Garfield (1995) that as a therapist, one must often experience very primitive and painful affects, such as emptiness, hopelessness and meaninglessness if one is to remain in contact with a psychotic patient. Work with such

patients requires a great deal of emotional effort. I also agree that in the service of acknowledging the accuracy of the patient's reality testing, it is important to be candid and honest with the patient about one's thoughts and feelings. Not to reveal aspects of oneself at certain moments may confirm the patient's fear that such feelings are too painful to bear and frightening to talk about.

Like writers in the Sullivanian tradition, I think it is crucial to work with the patient to identify and verbalize his inner states. In work with a regressed psychotic patient, one must often start with helping him attach words to sensations, affects, fantasies and ideas. No further psychotherapy is possible if the patient does not have a lexicon for his inner experience. In the process of this, the patient is gradually drawn into the essential task of language use that connects him with other subjects. Semrad's emphasis on the need to help the patient become aware of his inner life, despite the considerable pain this generates, is essential.

Writers from the Interpersonal School, however, are often not specific about diagnosis or technique. Like the traditional psychoanalytic theorists, schizophrenic psychopathology is understood to exist on a continuum with neurosis. Specific differences in ego functioning and language use are not emphasized.

Kleinian analysts have contributed an enormous amount to work with psychotic patients. Their descriptions of primitive defences such as splitting, projective identification and denial have been very helpful. Their emphasis on the differences between paranoid-schizoid anxieties and depressive concerns has also been very important. Their account of the role of primitive object relations and affects such as envy, contempt, devaluation and idealization has helped clarify a number of important transference phenomena. Also, their emphasis upon the use of countertransference as a guide to the internal life of the psychotic patient (Racker, 1968) is crucial.

However, my approach differs from these early Kleinian authors in several ways. Unlike theorists from the perspective of traditional ego psychology, the earliest Kleinian analysts discussed (with the exception of Ogden) do not appear to interpret from "surface to depth". If the examples they give reflect their practice, they direct their interpretations to what seem to be the deepest and most intense primitive anxieties associated with the patient's fantasy. Their interventions tend to focus on introjective and projective mechanisms connected with primitive fantasies about body parts and contents. These interventions appear to have a somewhat stereotyped and arbitrary quality, and do not seem to spring from the patient's particular associations.

I am concerned not only that these interpretations may not be accurate, but also that they do not sufficiently account for the patient's need for a "psychic surface"; that is, a cognitive realm that is *not* so immediately connected to what is primitive in the patient. If concept and symbol formation is to occur, it must take place in a "mental realm" that has boundaries and integrity of its own, and exists separately from body organs and physiological states. To deemphasize surface material in psychotic patients and focus so consistently on what is "deep" or "primitive" may be to undermine the patient's need to erect a repressive barrier

between conscious and unconscious, between secondary process and primary process.

To make this point is not to embrace Federn's suggestion that we should ignore or encapsulate what is psychotic in the patient. Rather, it is to acknowledge that the psychotic patient needs an intact surface as well as a vital depth, and that one must proceed gradually from one to the other. Also, I think that a too aggressive interpretation of depth material may undermine the patient's experience of having an intact self-object boundary by skipping over the psychic surface and "magically" reading the patient's deepest thoughts.

Related to this point is the use of complex verbal interventions by a number of early Kleinian analysts. In the examples I have given, the analyst makes rather lengthy and complicated statements to the patient. To understand and make use of these interventions requires considerable cognitive skills including attention, concentration, memory and a facility for class concept use. We know that patients diagnosed with schizophrenia have profound troubles especially in these areas. To make such interpretations, we must assume that there exists a nonpsychotic part of the personality that remains intact, a kind of verbally sophisticated homunculus, in which these verbal skills remain preserved, that can attend to and integrate complex interpretations.

I think that this is a questionable assumption. What this nonpsychotic part of the personality is actually like in any particular patient is very unclear. It may be adept at symbol use, or it may not. It may suffer from some of the same difficulties in symbol use as its psychotic counterpart. It may play a large role in overall ego functioning, or only a small one. Even if we are optimistic, and assume that alongside the psychotic ego there exists an ego that is completely normal, and in which all the essential ego functions are preserved, that does not mean that such an ego could assimilate the lengthy and complex interpretations that are reported in the writings of the early Kleinian analysts. There are many verbally sophisticated neurotic patients in psychoanalysis who cannot assimilate verbally complicated interventions.

Finally, I think that the early Kleinian analysts who work with psychotic patients approach the therapeutic task as if the patient were a codemaker and the therapist a kind of codebreaker. The patient presents verbally obscure and complex material and it is the therapist's job to decode it. While some of these decodings may be accurate, they call upon the therapist to make virtuoso performances of translation. Moreover, they do not address the way in which patient and therapist have become engaged in the codemaking-codebreaking process. My own view is that it would be better for the therapist to remain "naive" in his stance, to not assume too much of an understanding based on translations of obscure symbols, but to point out to the patient that he is being obscure. To not do this, in many cases, is to undermine the patient's reality testing.

If an average social observer cannot understand what the patient is saying, then he needs to know this. If the patient needs a trained psychotherapist familiar with primitive fantasies to understand him, then there is certainly something

amiss in the way he communicates. It is important to point out these problems in communication not only to help the patient appreciate the social reality of the interaction, but also to begin an exploration of the defensive functions that his obscurity may have. My approach attempts to address this issue.

In terms of recent American writers, as I noted above, my approach is similar to that of Marcus in that it attempts to clarify the way the mind is structured in psychosis and designs a technical method based on that understanding. We share the belief that uncanny sensory experiences (e.g. hallucinations) result from a combination of perceptual experience and affects. We both emphasize observing the way the ego functions in psychosis and how to address its limitations. My approach differs, I believe, in that I place slightly more emphasis on the technical details of translating perceptions and affects into words (see Chapter 4, "naming" and "enlargement", and Chapter 5, e.g. Ms. Williams, Ms. Hunt and Ms. Bender), and on the details of building an alliance over time with a psychotic patient (see Chapter 4, "building the interpersonal relationship", e.g. Ms. Williams). I also place more emphasis on paranoia (see Chapter 8).

In terms of Garfield's work, my approach is similar in its focus on affect. Like him, I believe that painful affects are often responsible for setting psychotic processes in motion. And, like him, I focus on perceptual and sensory experiences as conduits of important affects and subjective experience. I agree with his emphasis on countertransference as a crucial tool in understanding the patient's experience. My approach differs, I think, in that I focus somewhat more on the impairments of ego functioning in psychosis, and on how an understanding of these impairments guides technique.

Notes

1 Greenberg (2004) states that affects are the "tacit appraisal of a situation in terms of personal goals". Affects mark the realistic position of the self in present reality, the status of the self in its characteristic personal relations with others, and emotional reactions to long-standing fantasies (that is, wishful narratives or more static images of self-other relation). They are the emotional correlates of the "core beliefs" of CBT.

2 CBT may also play a useful role in cognitive remediation (Penades et al., 2006).

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APPENDIX

Patient sample

In selecting patients to discuss in this book, I have used both DSM-IV TR (2000) criteria (which are essentially the same as DSM-V criteria) as well as Kernberg's (1975, 1984) classification system. When affective symptoms have been present, they have been brief in relation to the total duration of the disorder. All the patients described in the Appendix meet DSM-IV TR criteria for the diagnosis of schizophrenia except one, Mr. Tilden. This patient clearly meets criteria for schizotypal disorder, but it is a matter of opinion whether he meets the criteria for schizophrenia. I include him in the discussion because even though he may not fulfil the DSM criteria, I believe he is "structurally" psychotic according to Kernberg's system. Also, he demonstrates several "forme fruste" examples of symptoms included in the diagnosis of schizophrenia such as end-of-the-world fantasies and looseness of association.

In the pages that follow, I will provide a short synopsis of the histories of individuals who appear most frequently in examples. There are some other individuals who appear very briefly in clinical examples who are not included in the Appendix. Their clinical pictures are described in the text. Clearly, this is a heterogeneous group of patients, with a variety of strengths and problems. The heterogeneity of presentations is consistent with the findings of years of research concerning diagnosis.

Mary Williams

Mary Williams was a twenty-year-old woman from an impoverished city neighbourhood. She was born to teenage parents who were poor and had little education. Her physical development was normal. Her psychiatric symptoms as a child included social isolation, self-injury and aggressiveness. She was often afraid to be with other children, and often did not go to school, spending hours alone at neighbourhood video arcades. As she got older, she became more verbally and physically aggressive and bizarre. Finally, in her mid-teens, she ran away from home, crossing the country from Illinois to Texas, where she lived in a shelter for runaways.

At the time of her hospitalization in 1992, she was noted to have symptoms of depersonalization, derealization, looseness of association, tangentiality, circumstantiality, paranoid delusions (she thought her grandmother was a member of the Ku Klux Klan and intended to harm her) and auditory hallucinations (she heard the President talking to her). These symptoms had been present for two years, and had been treated, without benefit, with chlorpromazine 100 mg per day for several months before her hospitalization. The diagnosis made by several clinicians on admission was chronic undifferentiated schizophrenia according to DSM-III criteria. Psychological testing concluded that Ms. Williams had a "severe" loss of reality testing, a disturbed sense of boundaries and autistic and referential thinking, and that she felt that inanimate objects were alive.

It was not possible for the hospital staff to locate and contact Ms. Williams' family in Illinois and so no family history was available. A routine neurological exam revealed no abnormal findings. Ms. Williams was treated with fluphenazine 10 mg three times per day for the many months of her hospital stay. This was associated with a reduction of her auditory hallucinations and delusions, but not her thought disorder or bizarre behaviour.

Ms. Williams was an inpatient and subsequently a day hospital patient at the time of the treatment described here. She had abused alcohol, marijuana and phencyclidine in the past.

Deborah Weiss

Deborah Weiss was a 43-year-old Jewish woman from Colorado. She was raised by her parents and had one sister. There was no documented history of mental illness in her family. Her father was a high-school teacher, and her mother worked as a receptionist. She attended a local community college, and after graduation took a job as a receptionist at an insurance firm. During this time, she had some friendships.

Ms. Weiss had taken several trips to Israel and considered settling there, but ultimately never did. She had been brought up an Orthodox Jew, but became less observant as she got older. In her thirties, she was hospitalized for the first time, and never returned to work. Her functioning deteriorated progressively; over the course of the next thirteen years, she was hospitalized at least four times. Her symptoms included, at various times, auditory and visual hallucinations, persecutory and religious delusions, ideas of reference, depersonalization and derealization. Evidence of thought disorder included looseness of association, tangentiality and pressured speech.

Most prominent when she was symptomatic were paranoid ideas concerning those closest to her and ideas of reference. She thought that she saw evidence of the imminent return of the Messiah everywhere. When younger, she also had violent impulses she struggled to control. She wanted to kill her boss and others who offended her. She stated that when she felt even a minor frustration, "my initial thought is to attack, but I hold myself back." Referring to her

social isolation, she said, "There are cracks between people and me." Ms. Weiss complained bitterly of feeling dead, empty and lethargic and thought that something must be wrong with her physically. An extensive neurologic workup which was undertaken was negative. This workup included a neurologic exam, a CAT scan of the head, a lumbar puncture, an electroencephalogram, blood work and thyroid and viral studies.

Ms. Weiss had episodes of aggressive excitement, but there was no clear history of manic symptoms. She often felt lethargic and without energy, but this was not connected to a well-defined depression. Her course was not episodic, and she never returned to her premorbid state. Treatment with lithium (1800 mg per day), tricyclic antidepressants (e.g. desipramine 250 per day for two months and nortriptyline 100 mg per day for two months), MAO inhibitors (tranylcypromine sulfate 40 mg per day for six weeks), neuroleptics (e.g. haloperidol 10 mg per day for four months and loxapine 150 mg per day for three months) and anxiolytics was minimally helpful.

Ms. Weiss had abused alcohol, stimulants and morphine in the past, but was not taking these drugs at the time of the current treatment. She was diagnosed as having chronic paranoid schizophrenia by at least eight different clinicians using DSM-III and DSM-III-R criteria. No alternative diagnosis was proposed by any inpatient or outpatient facility. Ms. Weiss was an outpatient during the treatment described here.

Cathy Chen

Cathy Chen grew up in a suburban, middle-class household in San Francisco. Her early development was relatively normal. There were six children in the home: three girls and three boys. Ms. Chen described her mother as a very competent woman. She was a member of the city council, and very active in city and state politics. Ms. Chen's father, an electrical engineer, was, by contrast, often withdrawn. There was some evidence of suspiciousness in her mother, and at times her father seemed disorganized, but no family member had ever been hospitalized or taken psychiatric medication besides Ms. Chen.

Throughout her childhood and adolescence, Ms. Chen's mother imposed her unwelcome views upon her. Despite her love of sports, particularly swimming, her mother steered her toward a career in education. Despite paranoid thinking and social awkwardness, Ms. Chen was able to progress in school. After graduation, she went to work as a junior high-school teacher.

Several years later, Ms. Chen had an acute decompensation. She came to believe that she was responsible for the serious illness of the governor of California. She believed that she and a prominent Chinese-American newscaster were the same person. She had marked ideas of reference, and thought that her fellow teachers were sending surreptitious messages about her on the school public address system. She experienced the somatic delusion that she had a mastectomy. She believed literally that decomposing seaweed was all over her neck and

back, and that termites were burrowing in her heart. She had frequent experiences of derealization and depersonalization, and complained of feeling lifeless and mechanical. She was very isolated socially. Her hospitalization occurred after an explosion of anger and incoherence during an airplane flight in which she intentionally hit her head on a door.

During her two-week hospitalization, she was noted to have looseness of association, ideas of reference, tangentiality, over-abstract and concrete thinking and inappropriate affect. She was treated successively with Triavil 4-25, two tablets three times per day for two months, and then haloperidol 20 mg per day for seven months following her hospital stay. The haloperidol treatment was associated with a reduction in auditory hallucinations and paranoid ideas. However, some paranoid ideas and ideas of reference, tangentiality, pressured speech, over-abstract and concrete thinking and inappropriate affect remained chronic despite neuroleptic treatment.

Ms. Chen did not have a history of depressive or manic symptoms, and her course was chronic. She was evaluated by a neurologist, and her neurologic exam and an electroencephalogram were within normal limits. Ms. Chen was diagnosed as having chronic paranoid schizophrenia according to DSM-III-R criteria by at least three clinicians. She did not abuse illegal drugs. She was an outpatient at the time of the psychotherapy described in this book.

Helen Jackson

Helen Jackson was an African-American woman in her early twenties who came from the rural South. The Jacksons had four children but, after a financial reversal, decided that they could no longer afford to raise them all. As an infant, Ms. Jackson was sent to live with cousins, the Jordans. The patient lived with Mrs. Jordan until she was in high school, at which point Mrs. Jordan suffered a stroke and was institutionalized. Her biological parents were intermittently involved in Ms. Jackson's life before Mrs. Jordan's institutionalization. As a child, Ms. Jackson had some friendships, but as she got older, she became more socially isolated. Academically, she was able to do fairly well in high school, and took some computer training courses after graduation. She had a few short-lived relationships with men.

Following this, she worked at a series of unskilled jobs and her functioning deteriorated. This deterioration accelerated following the incapacitation of Mrs. Jordan. Ms. Jackson began to act out. For example, while taking an aerobics class, she criticized the instructor for faulty technique and called the manager to have him removed. Following a financial disappointment, she became acutely psychotic. She was agitated, had grandiose delusions and her behaviour was disorganized. She showed evidence of looseness of association, tangentiality, circumstantiality, pressured speech, neologisms and restricted, inappropriate and blunted affect. She was admitted to hospital on several occasions, where she stayed for a few months each time. She was treated with fluphenazine 20 mg per day for several months with some improvement.

Subsequently, as an outpatient, she was treated with loxapine succinate 800 mg per day for two months, and trifluoperazine 10 mg for three months, as well as a variety of other neuroleptics at unknown dosages. Antipsychotic treatment resulted in a decrease in agitation and bizarre behaviour, but behavioural disorganization, looseness of association, pressured speech and inappropriate affect remained chronic despite medication treatment.

Ms. Jackson was evaluated as a young adult for headaches following a car accident. Her neurological exam was normal, as were skull X-rays. A CAT scan revealed evidence of a "slight" concussion.

Ms. Jackson never had auditory hallucinations. She had no history of a depressive syndrome or manic symptoms. She denied a history of drug use. She was diagnosed in each hospital as having chronic undifferentiated schizophrenia according to DSM-III criteria. As an outpatient, she was also diagnosed as having schizophrenia. She was being treated as an outpatient during the period reviewed in this book.

Dorothy Hunt

Dorothy Hunt was a twenty-five-year-old woman who came originally from the Midwest. She was raised by her grandfather, a retired widower, with the help of his unmarried sister, after her mother abandoned her at six weeks of age. From childhood, Ms. Hunt was clearly different from other children, and acted in unpredictable and eccentric ways. She was teased and shunned by her peers. At the age of twenty, she developed frank psychotic symptoms. She heard voices coming from the mailbox outside her home, which told her to kill her cousin, and she felt that her landlord had hired assassins to murder her. She thought that "music particles" had entered her clothes and believed that ghosts haunted her and that they exerted influence over her. She had prominent ideas of reference, inappropriate affect and felt that thoughts became "ethereal substances" that were dangerous to her. On occasion, she rubbed her legs with sandpaper. On admission to the hospital, she was noted to have looseness of association, tangentiality, circumstantiality, thought blocking and thought insertion.

Ms. Hunt had no history of depressive or melancholic symptoms, or manic symptoms. At least three different clinicians diagnosed chronic undifferentiated schizophrenia according to DSM-III-R criteria. Psychological testing noted an "absence of a feeling of reality" and concurred with the diagnosis of undifferentiated schizophrenia.

Despite numerous efforts, it was not possible to obtain a family history of psychiatric disorder from Ms. Hunt's relatives. She had no history of drug abuse. No specific neurological evaluation was performed beyond a brief neurological exam, which was normal.

Ms. Hunt was hospitalized on four occasions for several months at a time. She was treated with thiothixene 30 mg per day for four months, and trifluoperazine 30 mg per day for six weeks. These medications reduced her agitation and

auditory hallucinations, but did not eliminate the presence of pressured speech, tangentiality, circumstantiality, inappropriate affect, paranoid ideas or bizarre behaviour.

Roger DeVito

Roger DeVito was a man in his mid-thirties who had spent his childhood in Sicily. He came from a very large family of seven children, and, having five younger siblings, felt that his parents neglected him as a result. He recalled feeling empty inside since early childhood. Despite these troubles, he had a fairly good social adaptation and a number of friendships as a child. Mr. DeVito's parents died in a boating accident when he was seventeen, and he and several of his siblings lived with his aunt and uncle in the United States thereafter. He did well in school and eventually completed college and graduate school in accounting.

In his mid-twenties, Mr. DeVito had the first of a series of numerous hospitalizations. His symptoms included prominent paranoid delusions. He believed that the head of a Mafia crime family was somehow living inside his heart, that this man controlled his behaviour and that he often spoke to him. He heard other voices that criticized him and, on occasion, issued commands. "You will discover three of your family members murdered," they said, "and it will be because of you." Sometimes, Mr. DeVito would act bizarrely. Once, he took a ferry to a remote island off the Oregon coast and wandered about until he was discovered by a park ranger. On another occasion, he built and erected a dozen religious statues in a downtown shopping mall. Several times, he was found in a catatonic posture, and would not speak.

Prominent among Mr. DeVito's chronic symptoms was a sense of inner deadness, alternating with emptiness. He felt that he was not the same as other people, that he lacked some essential human ingredient. He had some friends, but felt mechanical and dead with them.

Mr. DeVito's illness included some affective symptoms. At times, he became depressed, with poor sleep, poor appetite and suicidal ideas. At other times, he seemed agitated and had increased energy and irritability. However, euphoria, increased talking, increased spending of money, racing thoughts, flight of ideas and the planning of new projects were not prominent features of his illness.

Due to his affective symptoms, the diagnosis of bipolar affective disorder with psychotic features was made by several clinicians. However, it should be noted that Mr. DeVito's belief concerning the gangster who lived in his heart continued for years, and did not recede with the resolution of his affective symptoms. Moreover, there had been numerous episodes of psychotic symptomatology such as paranoid ideas, auditory hallucinations and delusions, which occurred in the absence of any affective symptoms. The diagnosis in this case is not completely clear-cut, but it seems to me that the most accurate formulation is schizoaffective disorder according to DSM-III-R. Mr. DeVito was diagnosed variously as having schizophrenia, atypical psychosis, bipolar disorder with psychotic features and

schizoaffective disorder. As time went on, the most frequent diagnosis he was given was schizoaffective disorder according to DSM-III-R. Psychological testing was done, and concluded, not surprisingly, that Mr. DeVito had a mixture of schizophrenic and affective symptoms.

Mr. DeVito had numerous psychiatric hospitalizations whose durations ranged from one to six months. He was treated with neuroleptics, inpatient electroconvulsive therapy (ECT), lithium carbonate, valproic acid and antidepressants. Treatment with fluphenazine 30 mg per day for four months, lithium carbonate 2400 mg per day (with a blood level of 0.8 meq/L) for six months and imipramine 200 mg per day for six weeks resulted in only modest benefit, and did not prevent the development of paranoid delusions, auditory hallucinations or agitated behaviour.

After several episodes of unresponsiveness Mr. DeVito had an evaluation as an inpatient by a neurologist. He was noted to have a normal neurological exam with a normal CAT scan, MRI scan and electroencephalogram. The family reported schizophrenia in one first-degree relative. Mr. DeVito did not use alcohol or illicit drugs.

Claudia Sanchez

Claudia Sanchez was a twenty-five-year-old Hispanic woman who grew up in California. She came from a large family who had emmigrated to the United States before she was born. Her father was a high-school Spanish teacher and her mother worked at a local restaurant. She had two brothers, one older, one younger. Ms. Sanchez seemed to develop normally with good friendships and without excessive anxieties. She attended a local community college, and after doing extremely well, transferred to the University of California, Berkeley, where she continued to do well academically and socially.

In her late teens, Ms. Sanchez began to feel anxious and depressed. She also began to be suspicious. Her first psychiatric hospitalization occurred before the end of high school. Following another hospitalization two years later in which she also reported rapid thinking and pressured speech, she was diagnosed with bipolar disorder. Eventually she developed auditory and visual hallucinations and poor sleep, and was hospitalized again. Her symptoms included: visual and auditory hallucinations, somatic hallucinations, disorganized speech, perseveration, paranoid delusions and ideas of reference (she believed that movies were referring to her). She came to believe she had been chosen for a special mission to help mankind.

During this time she was diagnosed with schizoaffective disorder and began treatment with a long list of antipsychotic and mood-stabilizing medications. These included: trifluoperazine, thiothixene, fluphenazine oral and IM, perphenazine, imipramine, amitriptyline, clomipramine, carbamazepine, valproic acid and oxcarbazepine. Later on, she was treated with ziprasidone, risperidone, olanzapine, fluoxetine, paroxetine and bupropion. None of these medications had a

significant effect on her psychotic symptoms. Some were discontinued because of side effects, and the remainder seemed to have been tried at adequate dosages for an appropriate duration. Clozapine was not used because two challenges resulted in a significant drop in her white blood count.

Over the course of about ten years Ms. Sanchez had numerous psychiatric hospitalizations while experiencing persecutory auditory and visual hallucinations and paranoid delusions. In addition, Ms. Sanchez had various somatic hallucinations including the perception that there was an electric current running through her legs. She also felt that objects in the external world were "not really solid". She said that at these moments she felt like Alice in Wonderland. Except for the very beginning of her illness, her psychotic episodes occurred without evidence of significant mood symptoms. During this period, Ms. Sanchez could not work and was socially isolated.

During one of her hospitalizations, Ms. Sanchez met an occupational therapist, Ms. O, whom she liked immensely. Ms. O was warm and engaging and Ms. Sanchez felt enormously supported. In the course of time, Ms. O was transferred to another hospital unit. At first Ms. Sanchez was disappointed, but eventually she became angry and then suspicious. She began to hear a persecutory voice that sounded like Ms. O's. The voice of Ms. O was imperious and demanding and crushed Ms. Sanchez' sense of worth, leaving her feeling lethargic and hopeless.

Ms. Sanchez' family reported a history of both affective illness and schizophrenia in the extended family.

Norah Kelly

Norah Kelly was a thirty-year-old woman when she began psychotherapy with Dr. Y. She came from a very large family of ten, and lived with her mother and stepfather in a remote rural area in the northwestern United States. She had finished a nationally known music academy, and, for a time, worked as a singer for a well-respected opera company in the Midwest. Her father had been a professional singer and had expected his daughter to follow in his footsteps and go beyond. Ms. Kelly had taken singing and acting lessons since she was a girl. As an adult, she had few friends besides the acquaintances in her opera company, and only a very few romantic relationships. She lived with an aunt she knew in St. Louis. During her childhood, her parents had a long and unhappy relationship characterized by distance and silence.

Ms. Kelly began to have psychotic symptoms at the age of twenty-five. These followed an incident in which while she was a camp counsellor, a young boy had fallen down a gated flight of stairs and been severely injured. It was not clear whether he fell because Norah had forgotten to close the gate properly or because the gate was faulty. Ms. Kelly felt extremely burdened with guilt. Her symptoms included paranoid ideas, severe hypochondriasis and disorganized thinking. She believed that she had been recruited by a conclave of God's emissaries who communicated with her often. The communications to her were

cryptic, taking the form of colours that people wore and specially coded words that people uttered.

Ms. Kelly agonized about the mission she had been recruited for. She was to forgo her own personal ambitions and pleasures to help save the world. She felt honoured to be specially selected but also oppressed by the responsibility and obligation. This Messianic mission became the central concern of Ms. Kelly's life. She believed that her brain had been altered to control her participation in this mission. Sometimes the emissaries communicated to Ms. Kelly by means of voicemail messages on her cellphone and it was not entirely clear whether this was a delusional memory, or whether she actually heard a voice talking to her.

Ms. Kelly came to believe that strange things were happening whenever she left her apartment. She felt that somehow strangers she met could alter her voice. When she spoke at these times, she could not recognize her own voice. Sometimes she felt that her voice had been replaced by those of prominent figures in the news.

As her psychosis progressed, Ms. Kelly became increasingly religious. Born Lutheran, she became interested in Catholicism and felt that attending Mass and saying the rosary were critical to her feeling better. She spent hours studying the history of the Church and the lives of the saints. Somehow, her devotion to these studies would save her, she thought.

Despite her psychotic symptoms, at no time did Ms. Kelly have a thought disorder. There was no pressured speech, no tangentiality, no circumstantiality, no looseness of association, no flight of ideas, no ideas of reference, no thought blocking and no thought insertion or withdrawal. She did not have restriction or blunting of affect, but, on the contrary, a full range of emotions. Her behaviour was never odd or bizarre and she was always able to maintain empathy with the social criteria of reality (Weissman, 1958; Kernberg, 1975, 1984). Also, despite the fact that her beliefs about the emissaries and her role as "The Servant" were very strong and directed her day-to-day functioning, intellectually she was able to entertain the possibility that she might be mistaken. Despite her symptoms, she continued to struggle with some of the many contradictions in her delusional beliefs.

At the age of twenty-five Ms. Kelly began a series of four hospitalizations. She was diagnosed with schizoaffective disorder and treated with a variety medications including aripiprazole (20 mg per day) ziprasidone (160 mg per day), olanzapine (unknown dose), risperidone (unknown dose), quetiapine (unknown dose), clozapine (up to 450 mg per day), valproic acid (1200 mg per day) and sertraline (150 mg per day), as well as trials of other mood stabilizers and antidepressants. While these treatments reduced her anxiety somewhat, they did not affect her paranoid or somatic delusions.

Kavi Singh

Kavi Singh was a thirty-year-old Hindu man, whose parents had emmigrated to New York City from Calcutta. He had eight psychiatric hospitalizations beginning when he was twenty-three. His symptoms included delusions of control (he felt

that other people could make him stand up and turn around), over-abstract, stilted and disorganized speech, loose associations, odd and bizarre behaviour, agitation, paranoid thoughts and guardedness. In addition, at times, Mr. Singh acknowledged grandiose delusions such as having special athletic talents. He believed that the god Krishna watched over him and called to him personally.

"It's like talking to a friend", Mr. Singh reported. Krishna taught him to see the world "in a whole new way". At other times, he hallucinated the malevolent voice of Vishnu who told him to destroy himself. Mr. Singh believed that he could read the minds of others, and that others could read his mind. He believed that he could communicate with his deceased ancestors. In addition, he reported that, when he was psychotic, he felt drawn to the teachings of Jesus Christ and he was tempted to renounce his devout Hinduism. He also believed that his brain had been taken over by alien forces. Mr. Singh had many of these symptoms for extended periods in the absence of any evidence of mania or depression. Eventually he was diagnosed as having schizoaffective disorder.

During the course of his psychotherapy, Mr. Singh reported that Krishna would tell him to share or withhold his thoughts from his therapist. Krishna spoke to him at least once each day. "I couldn't get through life without Krishna", he said. "I am never lonely." Krishna's advice reduced his anxieties about the future. "Krishna puts my uncertainty to rest." Feeling comfortable due to the support of Krishna made Mr. Singh feel optimistic about his readiness to "save humanity". When his therapist behaved in a way Mr. Singh did not like, Mr. Singh warned that Krishna would destroy him.

Mr. Singh had grown up the youngest of five children. His early development was unremarkable. His parents had an unhappy marriage which was painful for Mr. Singh. He did very well in school and had a number of friends. He had a variety of girlfriends with whom he was sexually active. He did very well academically, graduated college and attended an MBA programme at a well-known university. Following this, he was only able to work sporadically due to his illness. His siblings provided a great deal of social and financial support.

Over the course of his illness, Mr. Singh took a wide variety of medications. These included antipsychotics such as fluphenazine 15 mg per day, trifluoperazine 15 mg per day, aripiprazole 20 mg, ziprasidone up to 60 mg per day, olanzapine up to 40 mg, pimozide 8 mg per day and clozapine for a short time. He was also prescribed mood stabilizers such as lithium 1500 mg, valproic acid 1500 mg, carbamazepine (1000 mg per day) and lamotrigine 150 mg per day. In addition, he was treated with antidepressants such as venlafaxine and nortriptyline.

There was no history of significant drug or alcohol abuse.

The family denied any history of mental illness in Mr. Singh's relatives.

Steven Tilden

Steven Tilden is a somewhat unusual member of this patient sample in that he was never hospitalized. Moreover, he never experienced acute psychotic symptoms

such as auditory hallucinations, persistent delusions or grossly disorganized behaviour. Nevertheless, I think that including him in this sample of patients is justified.

Mr. Tilden was a 32-year-old man of Scottish heritage who lived in a large urban centre in the Southeast. He was a tall, heavyset man with curly blond hair. He was raised in an urban middle-class home, and grew up in a very large family which included four sisters and four brothers. His mother was a chemistry professor and his father a physicist. He described his father as intensely involved with him in an often controlling way. His mother was intrusive, irritable and sometimes frightening. Mr. Tilden's childhood was unremarkable except for a painful sense of isolation and disconnection from his peers.

Mr. Tilden left home to attend college in Michigan where he continued to feel socially isolated. After graduation, he worked in various marketing jobs and lived on his own. He decided to begin psychotherapy after his girlfriend of two months broke up with him.

When he started treatment, Mr. Tilden complained of intrusive preoccupations about his future success. Mostly, he thought about being an adored rock-and-roll star or being selected for promotion to a prominent position within his company. He also complained of problems with sorting out his thoughts, and that only a small portion of his mind was actually functioning. He felt that the phrases he chose to describe his thoughts and feelings were always "off the mark". His mind became "hollow" when he tried to accomplish an intellectual task. In addition, despite being an amateur bodybuilder who weighed over 220 pounds, he complained of feeling "lazy" and "unreal" in his legs and arms. He sometimes felt that people were going to attack him, but often was not certain that this was true.

Early in his psychotherapy, Mr. Tilden was pleased that this therapist said little during the sessions. When the therapist spoke at a time that he felt was inopportune, Mr. Tilden began a lengthy explanation that this behaviour was not to be repeated. He believed that the therapist wanted to control him and make him "lifelessly" normal. When the therapist interpreted that he wished to control her, Mr. Tilden insisted even more that the therapist be quiet. On one occasion, when the therapist interpreted his use of primitive projection, Mr. Tilden became agitated and walked out of the session.

In addition, Mr. Tilden often used idiosyncratic speech. He used private terms, some of which included Gaelic and Latin phrases, and often seemed unaware that the therapist might not be able to translate this speech into conventional language. This translation could eventually be accomplished, but Mr. Tilden's capacity to empathize with the therapist's position as a listener was limited.

At times of stress, Mr. Tilden seemed to have experiences similar to those of schizophrenic patients. When he began work after graduating college, he felt particularly lonely and shaky emotionally, and became preoccupied with the possibility of catastrophic earthquakes (unlikely events in Michigan). On another similar occasion, he became preoccupied with the thought that the destruction of the Earth's ozone layer would accelerate, leading to global destruction within

a very short time. These concerns seemed to his therapist to be reminiscent of end-of-the-world fantasies described by patients diagnosed with schizophrenia. Mr. Tilden's sense of personal vulnerability was often intense.

Mr. Tilden had occasional symptoms consistent with depression—some insomnia, crying, sadness and lack of energy. However, these never met DSM-III-R criteria for major depression or dysthymic disorder.

Now, according to DSM-III-R, Mr. Tilden might be diagnosed as having schizotypal personality disorder. Descriptively, this might be accurate. However, there is a question whether, according to Kernberg's criteria (1976, 1984), he can be diagnosed as having psychotic structure. As noted, when the therapist interpreted his use of projective identification and omnipotent control, he became more suspicious, agitated and guarded.

Since there are no independent and objective criteria to validate our current diagnostic categories, the diagnosis of this man is a matter of debate. Despite this uncertainty, I include him in this work because even if not "overtly" schizophrenic, he appears to be a "form fruste" of psychosis, presenting embryonic forms of psychotic symptomatology, dynamics and transference. As such, I believe his psychotherapy illustrates aspects of work with more frankly psychotic patients.

Mr. Tilden was treated at times with neuroleptics. He received trifluoperazine 5 mg per day, thiothixene 2 mg per day and perphenazine 4 mg per day, each for several months, without apparent benefit. He had no formal neurological evaluation.

There was no history of major mental illness in Mr. Tilden's first-degree relatives. He did not abuse alcohol or illegal drugs.

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