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Psychoanalytic Therapy of *Schizophrenia*

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HISTORY AND DEVELOPMENT

As early as the paper "On Psychotherapy," Sigmund Freud (1905/ 1953) expressed the hope that psychoanalytic technique would be modified so as to make possible a psychoanalytic psychotherapy for the psychoses. Freud maintained this guarded hopefulness for the psychoanalytic therapy of the functional psychoses to the end of his life (Freud, 1940/1964). In Switzerland, at the Zurich University Clinic Burgholzli, Jung (1907/1960a) attempted inpidual psychotherapy with schizophrenic patients based on Freud's psychoanalytic method and Bleuler's (1911/1950) investigations into the psychology of schizophrenia. Bleuler observed that discharges at Burgholzli had tripled since the introduction of Freudian understanding (Federn, 1943a). Fifty years later, in a paper read at the Second International Congress for Psychiatry, Jung (1960b) reiterated that schizophrenia can be completely treated and cured by psychotherapeutic means.

Among the significant contributors to early psychoanalytic approaches to the psychotherapy of schizophrenia, Abraham (1916/ 1927) described the oral dynamics in a case of simple schizophrenia treated by psychoanalysis.

Waelder (1925) emphasized the *"narcissistic* transference" in schizophrenia. Bychowski (1930) described the oral dynamics and maternal transference in a case of schizophrenia with delusions of persecution. Bychowski (1954) discussed analytic working-through and systematic correction of the schizophrenic ego regression, including transference, thinking, defense mechanisms, and other formal peculiarities, utilizing interpretation, confrontation addressed to the more adult ego sector, and supportive reassurance against overwhelming affective reactions. Ego fragmentation in schizophrenia was related to alternating and contradictory structural identifications.

In 1933 Federn (1934) gave a technical paper on the analysis of psychoses to the Training Institute of the Vienna Psychoanalytical Society. Federn cautioned against adverse environmental influences, increasing of regression, premature uncovering, and negative transference, as well as against "withholding the [positive] counter-transference" (p. 210) (in order to *establish* positive transference). Federn reported that often a recumbent position in treatment would increase schizophrenic symptoms. Psychotic regression was understood as a defense against unbearable conflicts. Federn later (1943b) suggested that "one wins the normal transference of the psychotic by sincerity, kindness, and understanding" (p. 251), and he emphasized that in psychosis ambivalence is replaced by split ego states. Federn (1943a) reported good results for modified psychoanalytic therapy

with a follow-up period of at least five years.

In the United States, Kempf (1919) at St. Elizabeth's Hospital in Washington, D.C., had reported a case of dementia praecox treated by a psychoanalytic approach. He observed that maintaining an altruistic transference against negative transference taxed the therapist's patience and endurance. The psychoanalytic treatment involved the gradual analysis over two years of the patient's hallucinations, delusions, and physical symptoms in relation to specific environmental influences. At Shepard and Enoch Pratt Hospital in Baltimore, Harry Stack Sullivan (1931/1953a) reported the first large-scale study of 100 male schizophrenic admissions treated by what would today be described as modified psychoanalytic psychotherapy. Sullivan began developing his psychodynamic interpersonal relations theory as early as 1925. Of the 100 schizophrenics, 22 had insidious onset and 78 had acute onset. Sullivan reported that less than 32% (7 patients) of those with insidious onset showed improvement. Approximately 61% (48 patients) of those with acute onset showed a marked improvement, including some who recovered entirely. Sullivan suggested that acute onset had a much better prognosis than insidious-onset schizophrenia.

In 1935 Fromm-Reichmann (1950; Bullard, 1959) came to Chestnut Lodge in Maryland, where she worked closely with Sullivan. Fromm-Reichmann developed a psychoanalytic psychotherapy of schizophrenia that

she revised over a period of more than 20 years. Prominent schizophrenia researchers from the "Chestnut Lodge School" include Arieti (1974), Burnham (Burnham, Gladstone, & Gibson, 1969), Feinsilver (1986), Lidz (1973), McGlashan (McGlashan, 1983; McGlashan & Keats, 1989), Pao (1979), Schulz (1975), Searles (1965), Stanton (Stanton & Schwartz, 1954; Stanton et al., 1984), Stierlin (Stierlin, Weber, Schmidt, & Simon, 1985), and Will (1961). It was Searles who called attention to the importance of transference-countertransference attunement at a time when such a position was heatedly disputed.

In England, Melanie Klein, a student of Abraham and Ferenczi, further developed her psychoanalytic theory of internalized object relations and early oral dynamics, including work with psychotics (1930, 1948, 1975). Kleinian analysts such as Bion (1954, 1957/1967), Rosenfeld (1965, 1969), and Segal (1973) routinely treated borderline and psychotic inpiduals in psychoanalysis utilizing interpretations of positive and negative transference phenomena, free association on the couch, and most important, interpretations focused on the manifest and latent anxieties and the transference psychosis. Kleinian analysts understand schizophrenic phenomenology as a defense against overwhelming annihilation and persecutory anxieties. Unconscious material is interpreted at the level of the greatest anxiety, to develop awareness of the links between fantasy and reality. Winnicott (1965), an early Kleinian, would later come to emphasize

maturational processes in infancy and early childhood, as well as environmental deficiencies and abnormalities related to the development of schizophrenic disorders. In Scotland, Fairbairn (1954) and Guntrip (1969) contributed to the development of psychoanalytic object relations theory, including its applications to schizophrenics.

Benedetti trained with Bleuler at Burgholzli and later studied with Bally, Boss, Sechehaye, and Mueller, and Rosen in the United States. The Swiss psychologist Sechehaye (1956) had developed her method of "symbolic realization" to enter into the delusional world of the schizophrenic, at first using the symbols as if she and the patient understood their meaning, permitting gratifications not available in current reality as part of the process. Benedetti (1987) has had a profound influence on European psychotherapy of schizophrenia over the last 30 years, particularly in Switzerland and Italy.

In the United States, Bak (1954), following Hartmann, suggested that the inability of the ego to neutralize aggression was instrumental in bringing about a defensive ego regression in schizophrenia. Eissler (1952) developed his concept of parameters in terms of the need to intentionally deviate from standard technique to meet the needs of schizophrenic as well as other difficult patients. Boyer and Giovacchini (1967,1990), Grotstein (1990), Kernberg (1975,1977), and Volkan (1976) have become mainstream proponents for integrating the ego psychological and object relational

psychoanalytic theories and treatment, with important implications for borderline conditions and schizophrenia.

Karon studied with Tomkins and edited the first two volumes of the latter's *Affect, Imagery, and Consciousness* (1962, 1963, 1991a, 1991b), whose emphasis on the neglected central role of affects in the human condition led to a conceptualization of schizophrenia as terror plus humiliation, the latter being a component of most psychopathology, according to Tomkins. Tomkins had required of his students a basic knowledge of Freud, Sullivan, and Fromm-Reichmann, among others. Karon interned with Rosen in 1955-1956. Rosen (1953, 1962) developed what would be described (at the suggestion of Federn) as the "method of direct psychoanalysis" for the treatment of psychotic states. Rosen's approach, as described in his papers, attempted to enter into the schizophrenic's delusional world and to speak directly to the schizophrenic's ego states of infancy and childhood. During that year, it became clear that Rosen himself was not that adequate a therapist—except for occasional impressive single sessions, in front of an audience, that may or may not have been of long-lasting benefit to the patient—but his early ideas were helpful when used and modified by three psychologists in training, Firestone (1957, 1984, 1988), Rosberg (Rosberg & Stunden, 1989, 1990), and Karon. Since the patients were all chronic and had previously been treated at the most prestigious and expensive hospitals in the United States without significant improvement, anything that worked was taken seriously. Frequent

intensive discussions of the meaning and technique and collaborative work led to a series of early papers (Karon, 1958; Karon & Rosberg, 1958a, 1958b; Rosberg & Karon, 1958,1959).

Tomkins recommended the work of Fairbairn (1954), which was obviously relevant, and that theorist influenced the subsequent development of this approach. Bettelheim's views (1955, 1956) were also helpful. Analysts and non-analysts alike usually describe schizophrenics as people who do not sound like anyone on the ward. But Bettelheim described them as ordinary people (children), albeit in deep trouble, and they seemed just like the people one saw on the ward. He was the first to say that every psychotic break is preceded or accompanied by a conscious and overwhelming fear of dying, adding that he had never seen anything in a schizophrenic adult or child that he had not seen normal people do in a concentration camp—that is, normal people subjected to continuous massive terror.

Karon first saw acute schizophrenic reactions as senior clinical psychologist at a reformatory for male adolescents in the late 1950s, and he was startled by how readily the inmates responded to this approach. After continuing to work with schizophrenics during a postdoctoral fellowship at a well-known psychiatric hospital (where he became disillusioned with the kinds of treatments that so-called psychoanalysts provided psychotic patients) and in private practice, Karon felt that systematic research was

clearly needed to demonstrate how powerful psychotherapy can be with this population.

After moving to Michigan State University, Karon undertook a research project (funded by the National Institute of Mental Health) at Detroit Psychiatric Institute and Michigan State University, working with center-city Detroit schizophrenics who were predominantly of lower socioeconomic class and poorly educated; 85% of them were black. Psychoanalytic psychotherapy was found to be more helpful than medication (as described below), an outcome that contrasts with many of the stereotypes about the kinds of patients who can benefit from psychodynamic therapy. The truth is that no patient is capable of benefiting from psychoanalytic psychotherapy if it is never made available.

During and after the Michigan State Psychotherapy Research Project, Karon continued his psychoanalytic training with Richard and Editha Sterba and psychoanalysts in Detroit trained by or influenced by the Sterbas.

Teixeira (1984) studied with Karon at Michigan State University, worked with in-patient and out-patient psychotics at a community mental health center, and then, applying this approach, developed and evaluated a psychoanalytic day treatment program for another community mental health center. Despite clear evidence of its effectiveness (Teixeira, 1982a), the

program was terminated after 18 months, supposedly because "psychoanalytic treatment makes psychotic patients worse"—that is, for political reasons that ignored the empirical findings—as unfortunately is so often the case (Gunderson & Mosher, 1975).

INCLUSION/EXCLUSION CRITERIA

Schizophrenics are a widely varied group of human beings. What they have in common are their drastic adjustment techniques. Insofar as they have anything else in common, they can be characterized by Bleuler's (1911/1950) primary symptoms: autism (withdrawal from people), the thought disorder (an inability to think logically when they want to), and an apparent absence of affect, or inappropriate affect. Bleuler's description of the affect as absent or inappropriate was mistaken. Massive chronic terror blanches out lesser affects and gives the impression of affective flatness. Some patients are not willing to communicate honestly, or even capable of thinking of the affect as fear, since fear is present for them all the time. Further, inappropriate affect may be inappropriate only in the eyes of an external observer.

Schizophrenic inpiduals may also hallucinate, have delusions or catatonic stupor, and show a wide variety of other symptoms that, although Bleuler called them secondary, are notable for the severity with which they impair the schizophrenic's life. All of these may be understood as attempts to

deal with chronic terror. (Anxiety seems too mild a term.) Human beings do not tolerate chronic terror well.

A therapist can use *DSM-IV* (APA, 1994) criteria to make sure his or her patients are similar to those other researchers and clinicians refer to as schizophrenic, but *DSM-IV* criteria are arbitrary and make distinctions that are not clinically relevant and statements about these patients that are not true. For example, almost all psychoanalytic psychotherapists of any theoretical school emphasize the role of anxiety, terror, panic, or specific anxieties, and all the so-called antipsychotic medications are known to greatly blunt the affect system and anxiety. (This is why they were originally termed major tranquilizers.) But anxiety in schizophrenic patients is not mentioned at all in *DSM-IV.*

At the reformatory for male adolescents, Karon instituted five daily sessions of psychotherapy followed by once-a-week psychotherapy without medication for all apparently schizophrenic inmates. During a six-month period, no patients functioned on a psychotic level after the first week of treatment. (Patients were seen usually within 24 hours of their psychotic break.) Before psychotherapy was available and after it was no longer available, one or two schizophrenic patients were transferred each month to the state hospital and treated with medication; at this time, before the politics underlying deinstitutionalization had been set in motion, the typical hospital

stay was two years. All these patients came from the same reformatory population, but *DSM-IV* makes it seem an irrelevant comparison contrasting those with access to psychotherapy and those with no such access. The adequately treated (psychotherapeutically) acute patients would be diagnosed with brief psychotic disorder, and the inadequately treated (medication) acute patients would be diagnosed with schizophrenia, when the only real difference between them was the adequacy of treatment, not the severity of the disorder. Irrespective of treatment, patients with the same symptoms are classified by *DSM-IV* as suffering from brief psychotic disorder, schizophreniform disorder, or schizophrenia solely on the basis of how long they stay sick, obscuring the fact that inadequate treatments may lead to avoidable chronicity.

The existence in *DSM-III-R* of the category "schizophrenia in remission," to be used "when a person with a history of Schizophrenia is free of all signs of the disturbance," implied that no schizophrenic ever truly recovered (and pessimistically biased statistical compilations of outcome data by researchers who used records but did not directly examine the patients). Fortunately, this category was eliminated for *DSM-IV,* but added was the statement that "complete remission (i.e., a return to full premorbid functioning) is probably not common in this disorder" (APA, 1994, p. 282). Every existing long-term follow-up study, however, shows that approximately 30% of schizophrenics eventually fully recover, that this recovery rate is not a function of modern

treatment (Ciompi, 1980), and that using *DSM-III* diagnoses (which are very similar to DSM-IV for schizophrenics), as opposed to *DSM-1I* (which is similar to earlier diagnostic categories), makes no difference in long-term (25-year) prognosis (Harding, 1988; Harding, Zubin, & Strauss, 1987).

Since we see a continuity between schizophrenics and other human beings, and since the psychoanalytic therapy of every patient is uniquely related to his or her current needs and conflicts, it is not at all troubling, except for research purposes, if psychotherapists treat paranoid, schizo-affective, manic-depressive, borderline, or severe neurotics. On the other hand, we would like to exclude true brain-damage syndromes, such as are produced by lead poisoning, bacterial and viral infections, chronic alcohol or drug use (particularly if liver damage has occurred), cerebral embolisms, tumors, or brain damage resulting from previous psychiatric treatment, including not only psychosurgery but electroconvulsive therapy (ECT).

Unfortunately, the evidence that antipsychotic medication produces brain damage is becoming more and more alarming; not only does tarpe dyskinesia occur in 30% of patients on chronic medication for 5 years or more, and more than 50% of patients after 15 years (Glazer, Morgenstern, & Doucette, 1993), but recent studies of monozygotic twins discordant for schizophrenia reveal diffuse brain damage apparently accounted for by lifetime medication exposure (Suddath, Christison, Torrey, Casanova, &

Weinberger, 1990). This is denied in Suddath et al.'s article summary (since the obtained correlation coefficients as high as .50 reach only the .06 level of statistical significance, owing to the small number of cases) but is clearly revealed in their data. The Michigan psychotherapy study (Karon & VandenBos, 1981), which required examinations of all patients by neurologists and internists, nonetheless found that approximately 10% of those schizophrenics suffered from brain damage that was not discovered until after psychotherapy was initiated.

In the Michigan project (Karon & VandenBos, 1981), the clinical staff of the hospital had to diagnose the patient as clearly schizophrenic on the basis of intake interviews, social history, and ward functioning, supplemented if necessary by psychological testing; the ward chief had to diagnose the patient as clearly schizophrenic on review; and hospital internists and neurologists had to examine and clear the patient of organic pathology that might account for symptoms. A research psychologist reviewed all the materials and had to agree that the patient was clearly schizophrenic before the patient was randomly assigned to treatment. We took the simplest way to get clearly schizophrenic patients for the project: we selected the most severely ill in the hospital. However, we do not see a sharp line between schizophrenics and the rest of the human race.

DYNAMIC ISSUES IN SCHIZOPHRENIA

Schizophrenics are, as we said, a widely varying group of human beings who use drastic adaptation techniques to cope with massive terror. All of their symptoms may be understood as manifestations of the terror or as defenses against it. Schizophrenics must be treated as inpidually as any other patient, and everything the therapist knows about the human condition in all its variety is relevant.

Psychoanalytic writers have talked about conflict and deficit theories as if they were alternatives, but both are involved in the treatment of schizophrenia. Anything that makes life tougher is going to increase the probability of schizophrenia. The book *Psychotherapy of Schizophrenia: The Treatment of Choice* (Karon & VandenBos, 1981) has a chapter on dealing with economically poor people, suicidal problems, homicidal problems, alcoholism, drugs, racism and sexism, sleep problems, eating problems, and criminal activity. The editor wanted that chapter removed because "it did not deal with schizophrenics." The editor was right in that the book's advice would be equally helpful in treating any patient, schizophrenic or not, who had these problems, but the editor was wrong in that any therapist who is unwilling or unable to deal with these problems will fail with schizophrenics.

Most professionals continue to believe that the genetic basis of schizophrenia has been demonstrated. The Danish adoption studies (Rosenthal & Kety, 1968) are widely cited as the strongest evidence for the

genetic transmission of schizophrenia, despite gross errors and distortions of the data. The scientific flaws in these studies have been well documented (Lidz & Blatt, 1983; Lidz, Blatt, & Cook, 1981; Lewontin, Rose, & Kamin, 1984). Thus, Kety, Rosenthal, Wender, and Schulsinger (1968) reported that biological relatives of adopted schizophrenics have higher rates of schizophrenia than do normals, but adoptive relatives do not. However, in their data the increase in schizophrenia occurs largely in half-siblings, who are more likely to be schizophrenic than full siblings or parents. There is no genetic model consistent with those data.

Remove the half-siblings and the increase in schizophrenia is not statistically significant. In the Wender et al. (1971) study, adoptive parents whose children became schizophrenic were themselves more often hospitalized with psychiatric disorders, but that fact was not reported. Margaret Singer (Wynne, Singer, & Toohey, 1976), using her "communication deviance" measure, blindly differentiated adoptive parents of schizophrenics from adoptive parents whose children did not become schizophrenic, with no errors, from the Rorschachs gathered in that study. But Wender et al. (1977) did not report that finding, instead publishing what their research assistants found when misusing Singer's measure (i.e., when the measure was inaccurately scored, it did not differentiate parents of schizophrenics from parents of normals).

In the best adoption study to date (Tienari, 1992), Tienari and his coworkers in Finland carefully examined adoptive and biological parents and found that the best single predictor of whether an adopted inpidual would become schizophrenic was communication deviance measured from the interaction of the adoptive parents without the child present (so communication deviance is not a reaction to a disturbed child). Whether the biological parent was schizophrenic was not enough to predict whether the child would become schizophrenic, but parental schizophrenia did interact with parenting problems other than communication deviance, apparently making the child more vulnerable. The second-best predictor of schizophrenia was the interaction between adoptive parent-child conflict and whether the biological parent was schizophrenic (accounting for about half as much variance); the third-best predictor was the interaction between lack of empathy (of the adoptive parents) and whether the biological parent was schizophrenic (accounting for about half as much variance as the previous factor). Even this adoption study has a flaw: adoptions of children as old as four were included (in order to make the study parallel to the Danish studies). The data, however, are certainly far more scientifically accurate than any hitherto available.

These interactions (increased vulnerabilities) may represent genetic factors or very early environmental factors or even in utero maternal stress. Huttunen and Niskanen (1978) report data indicating that maternal stress

(death of husband) during pregnancy leads to a higher rate of schizophrenia than the same stress during the first year of the infant's life. Since circulating catecholamines pass through the placenta, this may be the mechanism of sensitization. Physiologically and clinically, schizophrenics manifest a chronic terror, and maternal stress could possibly lead to a vulnerability in the infant that would seem to be genetic in adoption studies.

In every case of schizophrenia we have ever treated, the patient's life history, from a subjective point of view, was so awful that the symptoms seemed inevitable. It may be true that the same patients were seen for years by professionals who did not want to know and that therefore the traumatic life history did not appear in the professional records. Thus, the voluminous records of 10 years of hospitalization of one patient revealed nothing more traumatic than that his family was poor and his father was an alcoholic. But therapy revealed that his mother would wrap a cloth around his neck and choke him for minor offenses, his father had anally raped him at the age of eight, and his priest had seduced him homosexually when he was an altar boy. This is simply one dramatic example of the fact that the lives of schizophrenics are not ordinary.

There is no single way into schizophrenia. All of us are capable of schizophrenic symptoms; the only differences among us are what kinds of stress, of what severity, would precipitate schizophrenic symptoms, and

which symptoms we would develop. The worse one's early life, the less current stress it takes. Of course, it is the meaning of the stress that determines its severity. Some people can cope with physical pain but not abandonment, some people can cope with abandonment but not physical pain. Women who develop postpartum psychoses have been made vulnerable by their life history and the meanings, unconscious as well as conscious, they attach to the experience of childbirth (Rosberg & Karon, 1958). If they had not borne a child, they might never have become psychotic.

Anything that makes life tougher increases the rate of schizophrenia. Living in poverty increases the rate simply because life is so painful for the poor in our society (Hollingshead & Redlich, 1958). Groups that suffer from discrimination have higher rates (Karon, 1975). Growing up in the city, not "downward drift," accounts for the urban increase in schizophrenia (Lewis, David, Andreasson, & Allebeck, 1992). The course and prognosis of schizophrenia in Western industrialized societies is more severe than in less industrialized societies because of the lack of social and personal support for the troubled person (Sartorius, Jablensky, & Shapiro, 1978).

The schizophrenic is simply the end of a continuum of adjustment—the human being in a great deal of trouble. As Charles Brenner (personal communication, 1994) aptly said, "The difference between neurotic, borderline, and psychotic is sick, sicker, sickest. But the mechanisms are the

same." Everything we learn about the human condition and about psychotherapy is relevant to treating schizophrenics, and everything we learn about schizophrenics sheds light on the human condition in general.

For most people, the most important environmental influence is family. Unfortunately, discussing parental factors makes parents feel guilty; there is even a parents' organization (National Alliance for the Mentally 111) that is dedicated to lobbying politically to have schizophrenia declared a biological disease so that parents can cope better with their guilt feelings.

Guilt, however, is inappropriate. Parents of schizophrenics are not criminals, but victims. No one, including the experts, knows how to be an ideal parent. We do know some ways in which parents can be destructive, and some ways parents can be helpful. If the experts do not agree (see the child-rearing section of any bookstore), parents certainly cannot be expected to. Many instances of hurtful parenting consist of well-intentioned parents carrying out bad advice from professionals, and sometimes from friends or family members. There are always destructive experiences in the lives of schizophrenics, but they do not necessarily involve the parents. In most cases, however, experiences with parents (or the lack of experiences, i.e., deficit) have contributed to the vulnerability.

One frequent way parents are unknowingly hurtful is by discouraging

the pre-schizophrenic from using people outside the immediate family as sources of information and corrective identifications. No one has ever had perfect parents, and normal development involves the use (including corrective identifications) of adults and peers outside the family to correct warps in the family. When this normal corrective process is interfered with, any problem in the family is greatly magnified. Parents have no idea that such interferences are hurtful; in the short run, intrafamilial conflicts are avoided.

A series of studies show that parents of schizophrenics, both natural and adoptive, manifest "communication deviance," which can be measured from observations of interaction, from the Rorschach, or from the Thematic Apperception Test (TAT). It can be roughly described as a tendency to keep communications unclear. It has been reported by clinicians that such important distinctions as those between parent and child and between male and female, and what those distinctions mean, as well as to whom particular thoughts, feelings, or needs belong, are often blurred in the families of schizophrenics. The most important study using communication deviance is, of course, the Tienari adoption study.

"Expressed emotionality" (a misnomer used in family research and clinical observations for intrusive hostility) also has been found to be hurtful to schizophrenic offspring (Leff & Vaughn, 1985).

The most general characterization of hurtful parental pressures, encompassing communication deviance and intrusive hostility, is "pathogenesis" (Karon & Widener, 1994; Meyer & Karon, 1967; Mitchell, 1968, 1969), measurable from the TAT. Pathogenesis refers to a tendency, when our needs conflict with those of someone who depends on us, to act on our own needs without being aware of the conflict. Pathogenesis may be understood as an unconscious defense against anxiety that all of us use but that parents of schizophrenics tend to use more often than others. Although pathogenic parenting, or deficit in parenting, can be observed, it is often subtle or not noticed, and the specific behaviors differ widely from family to family. Nonetheless, pathogenesis is pervasive and damaging psychologically to the emotional, cognitive, and social development of the child. Consciously, however, the mother (or father) seems caring, not only to others but to themselves as well.

Schizophrenic pathology is not the result of isolated traumatic experiences but a pattern of pressures that continues throughout childhood in somewhat changing form (e.g., Karon, 1960). Our psychological lives may be described in terms of the fantasy structures that we form on the basis of experience and of previous fantasy structures. These fantasy structures were originally conscious experiences. We use the term "fantasy structures" rather than "fantasies" because fantasies seem ephemeral. Fantasy structures are organized and maintain their internal structure and their relationship to

other fantasy structures over time. They can be remembered, repressed, or modified, but they play an enduring role in the conscious and unconscious psychological life. In addition to externally observable reality, they contain elements that are not perceptible to an external observer: feelings, internal states, memories, wishes, speculations, and imagination that reflect the maturational stage and limited information of the child (and adult).

We interpret our experiences of the present on the basis of the fantasy structures—conscious and unconscious—we formed in the past. It is in the nature of a schizophrenic's fantasy structures and their relationship to each other that we see the effects of childhood experiences on that person. The basic problems that begin in infancy are strengthened rather than reduced by the continuing interactions between the pre-schizophrenic child and the parents, particularly the mother (the more important parent for most children in our society). It is a branching process, with the fantasy structures formed in early infancy influencing how subsequent events are experienced, leading in turn to the next set of fantasy structures.

The end effect of an unfortunate childhood is that the child feels worthless and unlovable. But to be literally unlovable means that mother will not love you, that she will abandon you, and to the infant, this possibility means pain and death. This is the infantile terror that lurks behind the schizophrenic symptoms. The schizophrenic inpidual's whole life is organized

around the need to defend psychologically against this danger.

The child attempts to deny the "bad" mother, but this defense is self-defeating. Despite this denial, the child still feels rejected and the more "ideal" the rejecting mother, the more unlovable the child must be. The child tries to find something wrong with himself or herself to explain the feelings of rejection. But, when the child changes whatever he or she thinks is wrong, the rejection remains. The only solution is never to change, or to attempt to change in some way that is unchangeable. Either of these maneuvers allows the child to maintain the reassuring belief that if he or she did change, everything would be all right (and therefore that the mother does love her child, except for this unfortunate circumstance). The child also looks around for a second "mother" who can provide what the original mother did not—father, siblings, others—but the schizophrenic symptoms are evidence that the schizophrenic never succeeds in finding a "good" mother in these other persons. Rather, the schizophrenic usually finds new versions of the old problems. Typically, schizophrenics and pre-schizophrenics try all of these defenses frantically and unsuccessfully.

The problems of the schizophrenic are basically oral in the sense that they were first manifested in the relationship between mother and child in the early oral or infantile period. But the same psychological battles are fought successively on the oral, anal, and genital battlegrounds. When a

patient's life situation, as given meaning by conscious and unconscious fantasy structures, gives rise to a terror against which he or she cannot defend except by gross distortions of reality, hallucinations, paranoid delusions, becoming mute, and so forth, we call that person blatantly psychotic.

Two common misconceptions about schizophrenics are:

1. There are no repressions and hence no unconscious. But the unconscious of schizophrenics is not conscious; as compared with normals, they have a consciousness that is dominated by the unconscious, the way the manifest content of a dream is dominated by the unconscious but is not the raw unconscious itself.

2. There is no transference. In fact, much of the psychopathology of schizophrenia is nothing but transference to the world at large.

Catatonic stupor was first reported by Fromm-Reichmann (1939/ 1947) as including a conscious fear of dying "if I move." Experimental data from animal studies (Ratner, Karon, VandenBos, & Denny, 1981) suggest that the catatonic stupor is an evolutionarily adaptive terror state that occurs in almost all animals as the last stage when faced with death. When they become prey for hungry predators, both inpiduals and the species increase their survival chances by using this defense mechanism.

Hallucinations, according to our view, are nothing but wide-awake dreams, caused by intense motives, and understandable through using the same psychoanalytic principles that are applied to sleeping dreams, except

that while hallucinations may occur in any sensory modality, auditory hallucinations ("voices") are almost always present, because schizophrenia is an interpersonal disorder.

Withdrawal from others, or autism, one of Bleuler's primary symptoms, is clearly a defense against the anxiety engendered by interpersonal encounters, but isolation has also been shown to be related to increased hallucinations (Lapidus & Schmolling, 1975). And, of course, it prevents the growth processes that depend on our interactions with others, including corrective identifications.

In our experience, four principles account for most delusions (Karon, 1989a):

1. Transference to the world at large.

2. Defenses against pseudo-homosexual anxiety, as described by Freud (1911/1958), among them, projection, reaction formation, and displacement.

3. Being taught by family members peculiar concepts or meanings to words, which the patient then erroneously believes the rest of the world shares.

4. An inpidual's need to make sense out of his or her world and experiences, even if actual life experiences and symptomatic perceptions are bizarre and therefore require unusual explanations.

TREATMENT GOALS

The goals of treatment with schizophrenics are the goals of

psychoanalytic therapy with anyone, namely, to live a more fully human life. Freud is usually quoted as saying, *"Lieben und arbeiten"* (to be able to love and to work). According to Richard Sterba (personal communication, 1986), Freud usually added, "... and to be able to enjoy." It may require more work to achieve a given level of functioning with a schizophrenic, but the aim is to reach as high a level of functioning as possible in the time available. No course of analytic treatment is complete, just as no life history is complete, and there is no such thing as perfect functioning. Therapy, if successful, continues for the rest of the patient's life, albeit without an external therapist. (The treatment is conceptualized as primarily initiated by the therapist in most cases of psychosis, inasmuch as many patients feel that they could not survive without their symptoms and have no hope that better functioning is possible. This attitude changes as the therapeutic alliance is established to the point where both therapist and patient are equally involved, to where the patient is doing most of the work, and finally, at termination, the patient can continue to grow on his or her own.)

The criteria used by the raters and the interviewer in the Michigan State psychotherapy project may be used to give specificity to these goals:

1. *Ability to take care of one's self.* If we cannot take care of our own needs in fundamental ways—food, clothing, shelter, personal hygiene, personal safety—then we must be cared for. We directly take care of ourselves as far as possible, but all of us depend on others to help satisfy our needs, and we know and are capable of doing what is necessary to get others to help, whether by hiring, by friendship, or by personal relationship. If we cannot, then the only alternative is an institution—mental hospital,

board and care home, nursing home, or jail.

2. *Ability to work.* In our society, almost everyone works. A central part of our identity, work provides independence and enables us to take care of ourselves and, often, our families. In our society, 90% of married women, even with children and a working husband, need to work for economic reasons. Finishing school or getting a better education is an important preparatory goal and a temporary alternative (or supplement) to working. For some mothers with young children and others without support, being able to obtain welfare benefits to provide for their children (or themselves) is an important goal, and learning how to cope with the public agencies that administer the welfare, social security, or VA benefits to which they are entitled becomes an important issue, even if welfare is viewed as a safety net, not a permanent goal.

3. *Social adjustment.* We all need friends of both sexes and social relationships to make life worth living. The quality of our relationships with other human beings is perhaps the central issue in all psychotherapy, and particularly with schizophrenics.

4. *Sexual adjustment.* "Sexual adjustment" includes sexual satisfaction, the ability to love, and the ability to form an enduring relationship. The therapist should be willing to help with any sexual problems that exist and should help the patient deal with guilt over masturbation if he or she is not in a relationship. The therapist should not take a moralistic stance about the issue of heterosexual or homosexual relationships but should deal with fantasies as fantasies (and not actions) and evaluate relationships on the basis of their health for each of the partners. The therapist must not be committed to the patient being either heterosexual or homosexual but must let the patient follow his or her own path. However, most patients choose to be heterosexual unless (rarely) they have had a benign and gratifying homosexual relationship. Of course, all patients need to be instructed about birth control, avoiding unwanted pregnancies, and the realistic prevention of sexually transmitted diseases. They need both realistic advice and psychotherapeutic exploration of the fantasies and defenses that prevent them from making use of realistic information.

5. *Absence of hallucinations and delusions.* Obviously, these psychotic symptoms need to be resolved. Typically, the patient believes the hallucinations are reality and then, in therapy, begins to doubt them, to see them as possibly not real. Eventually, the patient understands them as waking dreams. The voices start as external reality, move to being an intermediate experience the patient uses for personal insight, and eventually become simply part of his or her thoughts.

6. *Becoming freer from anxiety and depression.* These unpleasant affects underlie most psychopathology, and improvement means living with less anxiety, less depression, and fewer incapacitating defenses against anxiety and depression.

7. *Amount of affect.* A person who cannot feel is only half alive. One defense against anger, terror, shame, and depression may be simply not to feel, but that is a very high price to pay. (Lobotomy, shock treatments, and even medications all lead to a diminution of the ability to feel.)

8. *Variety and spontaneity of affect.* The healthy affective life is varied and spontaneous. Affective reactions are a necessary part of logical and rational thinking, part of the evaluation of our own ongoing experience, as well as what makes life worth living.

9. *Satisfaction with life and self.* Patients need to like the kind of person they are and are becoming, and the life they are leading, with the bad parts in the past and the present making sense as, at worst, unavoidable evils and, at best, as learning experiences.

10. *Achievement of capabilities.* This treatment does not aim toward improvement by encapsulation or by giving up potentialities. Realistic goals are substituted for unrealistic fantasies. Therapists can sometimes help patients find realistic paths to what patients want but may falsely believe to be unrealistic. The therapist makes possible the patient's discovery even of what the therapist does not know. As patients get healthier, they frequently surprise us with their achievements.

11. *Benign versus malignant effect on others.* Psychopathic, exploitative, and hurtful, sometimes criminal relations with others do not represent health and are subjects for therapeutic exploration. Often these behaviors result from environments or families in which exploiter and victim are the only two roles available. The patient must be helped to develop healthier relationships. In particular the patient's destructive relationships with children, spouses and lovers, and other vulnerable people need to be worked on therapeutically, and the patient needs help in creating an interpersonal world of nonhurtful relationships.

To these criteria might be added:

12. *The ability to think realistically when one wants to*—in other words, the absence of the thought disorder. The Michigan project found that the thought disorder was the aspect of functioning in which psychoanalytic therapy most clearly produced earlier (Karon & O'Grady, 1969) and greater improvement than medication (Karon & VandenBos, 1981). Indeed, other investigators have reported with concern the limited effectiveness of neuroleptic medication in changing the thought disorder (e.g., Spohn, Coyne, Larson, Mittleman, Spray, & Hayes, 1986). The thought disorder is best

measured by tests like the Feldman-Drasgow Visual-Verbal Test, the Whitaker Index of Schizophrenic Thinking, the Porteus Mazes, the Thought Disorder Index, and a full Wechsler Intelligence Scale. In the Michigan project, the Feldman-Drasgow Visual-Verbal Test (which is not correlated with IQ within the normal range [Feldman & Drasgow, 1951]) best predicted long-term functioning and the ability to avoid hospitalization (Karon & O'Grady, 1970; Karon & VandenBos, 1974; Karon & VandenBos, 1981). The ability to think realistically seems to have an increasingly important effect on one's life as time goes by.

Of course, the change in the thought disorder with psychoanalytic therapy is not an isolated specific symptom change but correlates with changes in overall functioning. Both the unique predictive validity of the thought disorder and its correlation with other aspects of functioning are consistent with traditional views of schizophrenia (Bleuler, 1911/1950), and with other empirical data (e.g., Cancro, 1968,1969a, 1969b; Harrow & Marengo, 1986).

THEORY OF CHANGE

The first task of the therapist is to create a therapeutic alliance, that is, to form an alliance with the healthy part of the patient. With neurotic patients this task is easy; with schizophrenic patients it may be the center of the work for a long time.

One of the great mistakes in the literature is the discussion of insight therapy and relationship therapy as if they were alternatives. In fact, insight is only tolerable and attainable within the security of a warm, strong,

dependable, and safe relationship with the therapist. As Fairbairn (1954) said, people only get sick in relationships and therefore can only get better within a relationship.

Schizophrenics are withdrawn and autistic in their interpersonal relationships, but they are also dependent and very enmeshed psychologically in dyadic relationships.

The first function of the therapeutic relationship is to provide sufficient protection and gratification to overcome the *conscious* resistance of the patient. The patient is threatened by the possibility that the therapist will take away the psychotic symptoms (which are the best psychodynamic solutions the patient is capable of before treatment). This threat stirs up intolerable terror, mitigated only by the protection the therapist also provides. This protection is worth some cooperation, from the patient's standpoint.

Patients' search for a new "mother" continues in their illness; they are therefore susceptible to entering a relationship with the therapist. Of course, since this is a transference relationship, schizophrenics will eventually see in it the malevolent characteristics of their past relationships.

The transference relationship has two further functions in the psychotherapy of schizophrenia. The second function is to permit insight, as

in the analysis of neurotics. The patients relive feelings and experiences from the past, particularly those concerning their parents, with no awareness that they are from the past. The more severely disturbed the patient, the more obvious the transference reactions. Understanding the transference with psychotics is central. Contrary to Freud's mistaken notion that schizophrenic patients do not form a transference (e.g., 1917/1961, 1963, p. 447), much of the psychopathology of schizophrenia can be understood as transference to the world at large (Karon, 1963; Karon & VandenBos, 1981; Karon, 1992).

The third function of the transference is to transform the internalized fantasy structures based on the relationships with the parents by the internalization of the therapist. This process may be conceptualized as (1) internalizing the therapist as a more benign superego than the existing one based on the punitive part of the parents; (2) internalizing the therapist as a part of the ego, as a model of how one can be, much as the adolescent internalizes alternative objects (people) as models, eventually keeping what is useful and getting rid of what is not useful; and (3) internalizing the relationship with the therapist as a model for what a relationship with another human being might be like.

The role of insight in treating the schizophrenic is the same as in any psychoanalytic therapy. In classical terms, insight makes the unconscious conscious, changes the defenses in part by awareness, and makes the

connection between the past and the present. However, the role of insight and understanding as human adaptive functions is generally underappreciated because it is so obvious and ubiquitous in normal functioning. Nonetheless, it plays a central role in delusion formation as well as in healthy concept formation. The strong, benign, acceptant therapist who is willing to look at the world through the patient's eyes discovers with the patient when the delusions are inconsistent or ineffective and can then help the patient with knowledge both of outer reality and of psychodynamics to arrive at healthier and more effective thinking.

Central to the change process is the reduction of anxiety (terror). Every therapeutic interaction is aimed at the reduction of the terror to manageable proportions. Behind the inaccurate thinking (thought disorder), distorted perceptions, hallucinations, withdrawal, and inappropriate reactions to other people always lies the terror. As the terror is diminished, the other symptoms diminish as well. Other affects—rage, dependency, even love—may evoke terror. The patient must be helped to understand that affect is not the enemy, but a necessary part of being alive. There is no such thing as an irrational affect. If the patient is scared, there is something to be scared of. If the patient is angry, there is something hurting him or her. If the cause is not conscious, then something unconscious is the cause, and it needs to be discovered. If the cause is not in the present, then it is in the past and something in the present symbolizes it. There is always an adequate cause for every emotion.

Flat emotion is usually a chronic terror state, blanching out other affects and sometimes, by its chronicity, not being labeled by the patient as terror; more often, the absence of affect is in the eye of the beholder rather than in the awareness of the patient. Some of the physiological mechanisms of anxiety arousal may attenuate in response to chronic high-level activation or to psychotropic medication, but the terror syndrome may nonetheless persist (Teixeira, 1982b).

Sequences of actions are often symptoms. Such symbolic (or symptomatic) actions are attempts to resolve unconscious conflicts or traumas from the past. But symptomatic acts, no matter how often repeated, do not resolve the conflict, undo the trauma, or reduce vulnerability. Only when the relationship between the symbolic act (or symptom) and the original traumatic experience is reconnected in consciousness can the person really overcome it.

TECHNIQUES

The most important thing for a therapist to remember is that every symptom of schizophrenia is meaningful and embedded in the life history of the patient. There is a difference between meaninglessness and obscure meaning. Schizophrenics do not understand their symptoms, and they are often geniuses at not communicating clearly what they do understand. They

do not even tell us that we are helping them, because they are afraid it will be used against them. Therapists who have worked only with neurotics are not prepared for working a long time without direct feedback from the patient. It is very frustrating.

In a hospital where the myth that schizophrenic patients cannot be helped is believed, a therapist can be helpful and not know it, then go away assuming that the work was of no value. Very often, a therapist learns from the family that the work helped the patient, or if the patient is in the hospital, the ward staff may report changes in the patient's behavior. (Sometimes the therapist has to educate family or ward staff as to which changes are healthy, not pathological.) Otherwise, therapists have to rely on past experience or their supervisors to sustain therapeutic effort with little or no feedback from patients. Even though the therapist will frequently be mistaken (because the patient is not communicating clearly), if he or she works long enough, the patient will usually get better.

Sometimes the therapist knows the patient is being helped from the nature of the patient's complaints. One patient complains, "You haven't helped me because I really don't like the guy I'm sleeping with, and I really don't enjoy sex very much." These complaints, which should be taken seriously, nonetheless indicate progress. When the patient started treatment, she felt that no man would want her. She also felt that if she dated a man and

said no to sex, he would kill her, and that if she did go to bed with him, the sex would kill her. Her present problems indicate that she has made enormous progress.

Obviously, the therapist must be able to tolerate being confused. A need for certainty, often masquerading as theoretical sophistication, is a good formula for bad therapy. If the therapist cannot tolerate being confused, he or she will not be able to tolerate the schizophrenic patient or the patient's confusion. Such tolerance does not mean that the therapist lives in an unreal world or is uncertain about reality, but rather that he or she is always willing to ask questions, think through problems, and live with areas of uncertainty. The patients know they have not told you everything and that they do not understand much of what they have told you. Typically, they have been raised to pretend to certainty when there is no basis for it, and they have had parents and other authority figures in their lives who pretended to certainty about matters that were uncertain or even untrue. A therapist who can tolerate uncertainty is a good model for the patient. It is useful to tell patients when they complain that therapy is making them confused, "Good. You are not sick because you are confused. You are sick because you are certain of things which may not be true."

Typically, the distortions of schizophrenic inpiduals are attempts to deal with their problems symbolically: the contents of the unconscious are

expressed, and yet the inpidual is preserved from the awareness of what is being expressed. Schizophrenic persons are constantly trying to solve their problems, but they are too frightened to deal with the problems directly; they repress the real problems and deal with the symbols. This affords them a measure of relief, but they cannot solve their problems on a symbolic level. It is only after the specific unconscious problems have been made conscious that the patient is capable of seeing that a healthier resolution is possible.

As we have emphasized, human beings carry their childhood with them in their unconscious, and all neurotic and psychotic symptoms are attempts to solve lifelong problems that began in childhood and carried forward in ever-evolving fantasy structures about the world, the self, and others. A person's symptoms are always the best of a bad bargain, the best coping mechanisms available to him or her at the pretreatment stage.

One of the current misconceptions, even among sophisticated therapists, about the nature of schizophrenia is that the repressions are undone and the schizophrenic is aware of his unconscious. In our understanding, no one is more afraid of the contents of the unconscious than schizophrenic patients. The repressions are strong but brittle. Under stress, the unconscious may break through and then be repressed again. The bizarre language and thoughts often appear as a compromise formation, a partial repression—a displacement and condensation similar to a dream—rather

than total repression. Part of the reason for the notion that the repressions are undone in schizophrenia lies in the fact that certain impulses and ideas that are repressed in normal inpiduals become conscious in the schizophrenic. This material, which is often treated as "deep" in the analysis of neurotic patients, represents for schizophrenic patients nothing but another set of defenses against awareness of their real problems. Thus, Oedipal fantasies may be conscious, but the classic Oedipus complex does not have the significance for these patients originally ascribed to it by Freud. Instead, it serves as a defense against deeper and more frightening problems (Rosberg & Karon, 1958).

Of course, with all patients unconscious resistances are nothing more than the patient's usual defense mechanisms being used in the therapeutic hour. The resistances of the neurotic are primarily unconscious, but those of schizophrenics are conscious as well. Schizophrenic patients often feel that they will die without their psychotic adaptations. Therefore, they consciously do not cooperate. After all, why should they die for you?

A straightforward statement that "I will not let anyone kill you" is usually surprisingly helpful. Such a reassurance made early in therapy, even in the first session, helps to create a positive transference and is often useful later in the process in resolving impasses. The schizophrenic patient is always struggling with the fear of death and is relieved by such an attuned

interpretation. It may be argued that the reassurance is magical, but the real danger for most patients is from the internalized past or its reenactment in reality, and only a therapist can realistically protect them from such dangers.

The suicide rate among schizophrenics has been found to be 10-13%, which is at least as high as among depressives. Between 20% and 40% of schizophrenics attempt suicide. They are usually in despair. Consciously or unconsciously, suicidal patients are (1) trying to get even with someone else; or (2) projecting their conscience onto a possible rescuer, giving the "rescuer" a chance to decide (by intervening or not) whether they deserve to die, sometimes experienced as the hopeless cry, "Does anyone care if I survive?"; or (3) acting out a combination of compliance with an internalized parent whom they fantasied wanted them dead and escape from the same parent whom they fantasied wanted to hurt them. The therapist must provide hope within the psychotherapeutic relationship and deal with whichever of these factors are involved (or all of them, if the therapist does not know). The schizophrenic needs to know (1) that suicide is a surprisingly ineffective way to hurt parents, spouses, ex-lovers, ex-employers, and therapists; (2) that the therapist does not think he or she deserves to die; and (3) that he or she does not need to comply with a destructive parent, that living with therapy is a more effective escape from their pain than dying (Teixeira, 1984,1994).

With most schizophrenics the therapist can begin therapy by simply

asking, "What seems to be the trouble?" or, "How can I be helpful to you?" Most schizophrenic patients will begin to tell the therapist their problem, even many of those who are supposedly uncommunicative, incoherent, or lacking in insight. The aim is to find a problem that is also a problem from the patient's standpoint, that does not make sense to the patient, and that the therapist can help with. It does not have to be the patient's most important problem, but if the therapist is understanding and helpful about it, the patient is typically surprised, a therapeutic alliance begins to form, and the patient will communicate more central problems. (Of course, the patient may not realize that his or her most serious problems are symptoms, not facts of life, or that they can be helped.) The patient's problem is almost never a diagnosis (in the sense of *DSM-IV*); making a diagnosis solves only the insurance company's problem, the hospital's problem, and the therapist's record-keeping problem. Patients are well aware, whether they say so or not, that when therapists make a diagnosis (as opposed to finding out their problems in full phenomenological detail), they are not trying to solve the patients' problem but their own.

Typically, schizophrenic patients have felt deprived all their lives. It is important that the therapist do everything possible to be perceived as a giver, not a taker, and to be perceived as a nonpunisher and a nonpoisoner. The therapist must talk freely and try to be helpful on the verbal level. Even words may be experienced by the patient as a medium of exchange that can be given

and taken. The therapist must be seen as someone who does not demand but gives. There are many schizophrenic patients, however, to whom the therapist need only say, "All I have to offer you is understanding, but that is really a great deal."

The schizophrenic patient's knowledge of the world is usually more limited than that of the therapist for symptomatic, cultural, or even accidental reasons. The therapist who offers usable information becomes a helpful person in the patient's eyes. Of course, the patient may not be able to make use of the information and must be helped to understand that this incapacity is not a sin but a symptom, and that most of psychotherapy occurs when we know what to do but still cannot do it.

It is important, from the very first session, for the therapist to make clear to the patient that anything can be talked about: any thoughts, any feelings, any actions. Commonly, schizophrenic patients fear talking not merely because the therapist will disapprove of what they say but also because they fear that talking about a feeling, or even thinking it, means acting on it (e.g., getting angry means hitting someone) or that the thought or feeling itself is an action with immediate consequences in the external world. Again and again, the therapist must make the distinction between thoughts and actions: "It is all right to think or feel anything. The only things you have to control are your actions, because they are the only things that have

consequences in the outside world."

The only generally valid rule of interpretation, albeit imprecise, is that the therapist interprets what the patient can make use of at the time. Whether to interpret early or late, deep or shallow, defense or impulse, is always a clinical judgment that may be in error and may require constant revision. Sometimes a deep interpretation, even in the first sessions, will make sense out of experiences that otherwise overwhelm the patient; at other times, the same interpretation would be incomprehensible to the patient.

The second rule (following Freud) is that one interprets from the surface, in the sense of exhausting reality factors and realistic explanations first. Few patients are willing to consider psychodynamic interpretations until commonsense explanations are found wanting.

The third rule is that the therapist never does for a patient what the patient can do for him- or herself. But again, what patients can do for themselves is always a clinical judgment, subject to error. Obviously, this is true for self-care activities and interactions, but it is equally true for interpretations and insights. The patient's own insights are more effective than those derived directly from the therapist's interpretations. Further, a good interpretation is one that calls the patient's attention to something but that the patient can confirm from his or her own observations.

An important point of difference between our approach and many American psychoanalytic approaches (Gunderson & Mosher, 1975) is that we treat hallucinations like dreams; we use and interpret both in the same manner, using the associations of the patients supplemented by symbolic interpretations (which, of course, are not universal meanings but "good clinical guesses").

Schizophrenic hallucinations almost always involve voices, as well as other sensory modalities, because schizophrenia is an interpersonal disorder. One of the motives is often loneliness. It is always helpful for the therapist to attend to what is most important, and that involves understanding that the motives for hallucinating have to be stronger and more urgent than for dreams. Further, the hallucination, like the dream, acquires a second function for the patient in treatment. It is a communication between the patient's unconscious and the therapist: it is time for us to discuss this issue.

A terrifying hallucination or a recurrent nightmare becomes a symptom in its own right, and proper interpretive work relieves that symptom as the meanings are dealt with consciously.

It is important to help the patient discover that hallucinations are not real, that they do not represent real persons but are useful material from the unconscious. The patient at first will not accept such a view. When the patient

does accept it, the therapist has already undercut some of the function of the hallucinations, and the patient is already moving with the therapist toward health.

Patients may not tell therapists about their hallucinations for some time, because they do not trust therapists. Indeed, the hallucinations may even say, "Do not tell him about this," or give (wrong) interpretations in the therapist's voice.

In dealing with hallucinations, we attempt to get across to the patient our general view of psychotherapy, that the difficulties and symptoms are themselves the keys to solutions. It is the difference between learning from one's mistakes that everything is hopeless and one is bad or worthless and learning from the same mistakes something about what causes one to make those mistakes, what difficulties might continually arise and why, and consequently what might be done to change things. Eventually, the patient realizes that this is not merely a view of therapy but rather a general view of life, one that, unfortunately, our culture rarely teaches.

A persistent myth about schizophrenic delusions is that they are unchanging and unchangeable. Delusions are so different from the way most people think that to a superficial observer they seem unchanging. But rarely do delusions entirely fit reality; the patient is constantly repairing them. If an

interested and sympathetic therapist begins to consider them in detail, trying to follow their logic, the repair work can get frantic.

The therapist must be on the patient's side, fostering the therapeutic alliance by considering seriously the probability of what the patient relates, helping the patient to think clearly about the issues, and helping the patient to evaluate the evidence, remembering that just because something is improbable does not mean it is necessarily untrue, and even paranoids may be in actual danger of being killed.

The therapist should always ask for as much detail as possible, but in a kindly manner. Not only will details provide the material necessary for accurate interpretive work, but they will lead the patient to become aware of the inadequacies of his or her delusions as explanations and hence to become amenable to interpretation (i.e., to alternative explanation).

Therapeutically, it is often useful to tell the patient, "That is a brilliant explanation." The patient is usually startled that any professional would take his or her ideas seriously.

"You mean you think it is true."

If, as is usually the case, the therapist believes the patient can tolerate an explanation, the therapist might usefully say, "No, but that is because I

know some things about the human mind that you don't know yet, and I'll tell you if you're interested. But given what you do know, that is a brilliant explanation."

With such a nonhumiliating approach, it is often possible to get the most suspicious paranoid to consider what might be going on and the real meaning of delusions as an attempt to solve the terrifying dilemmas of his or her symptoms or life history.

Delusions based on transference can be interpreted, like all transferences. Delusions based on defenses against pseudo-homosexual anxiety can be dealt with by interpreting the fear that the patient's affectional hunger is homosexuality, dealing openly with and accepting his or her feelings of loneliness (rather than homosexuality), making it clear that we all need friends of both sexes, and, of course, reassuring the patient that all feelings and thoughts, including all sexual ones, are normal, and that if they are disturbing, they need to be understood. Sympathetic comments about the increasing acceptability of homosexual lifestyles are rarely reassuring to schizophrenics unless they have had a benign homosexual relationship.

And finally, delusions based on having been taught strange meanings of concepts in the family of origin can simply be pointed out when either the patient or the therapist becomes aware that the two of them are using the

same words with different meanings.

Most of this discussion has been directed to the specific differences in psychotherapy with schizophrenics. These differences are primarily necessary at the beginning of treatment, which gradually begins to follow the lines of the more familiar procedures of psychoanalytic psychotherapy with character disorders and neuroses, although as dynamic balances shift, some of these procedures may characterize short periods of the therapy even late in the process.

For adequate textbooks on therapeutic technique, we recommend Freud's *Introductory Lectures* (1917/1961,1963), *New Introductory Lectures* (1933/1964), and his papers on technique (*Therapy and Technique,* 1963), followed by Fromm-Reichmann's *Principles of Intensive Psychotherapy*

for basic analytic technique with neurotics and psychotics, Malan's *Inpidual Psychotherapy and the Science of Psychodynamics* (1979) for psychoanalytic psychotherapy and psychopathology, and Karon and VandenBos (1981) for work specifically with schizophrenics.

CASE EXAMPLES

The centrality of the conscious fear of death, the fear of annihilation, is well illustrated by the teenage female patient, diagnosed as hebephrenic on

intake for her second admission, who lapsed within 24 hours into a catatonic state that persisted for two weeks. She was chosen as the most unresponsive patient, in a biologically oriented hospital, to be interviewed for demonstration purposes; the psychiatric residents were curious (and skeptical) about psychodynamic treatment for schizophrenics. She was brought to her first interview, unmoving and mute.

Inasmuch as catatonics hear and see everything that is going on and are terrified, it is important for the therapist to do the talking and to address the terror directly, so as to begin to create a therapeutic alliance. The first session consisted of only the therapist (BK) speaking: "I won't let anyone kill you. I will protect you from anyone. I am on your side against your mother, your father, your sister, anyone. I will not let anyone kill you. But I will not let you stay crazy. There is no place in your insanity to hide. You can hear my voice, and the voices can't drown me out, or make me go away. But I won't hurt you, and I won't let anyone else hurt you. I can protect you against the voices. I won't let anybody kill you."

This motionless young woman got up and tried to leave. The therapist stopped her and continued his monologue. When the therapist was tired, after 30 minutes, the session was ended: "That's all for today." Of 12 psychiatrists who viewed the session through a one-way mirror, 10 delivered separate strong opinions that no patient should ever be interviewed in such a

manner and that the treatment was worthless. The next day, six of them apologized, because the catatonic young woman spontaneously approached the ward chief on rounds the next morning and asked, "May I please speak to the same doctor I saw yesterday?" After two weeks of daily therapy, the patient was discharged and continued on weekly outpatient therapy.

A 19-year-old was arrested and, in the local jail awaiting transfer, attempted suicide. He had been arrested five times previously. It later came to light that he was hallucinating, overtly (albeit uncomfortably) homosexual, alcoholic, and "experimenting" with codeine.

In the first session, he told the therapist (BK) that he had thought a psychologist might be able to help him, but that he had changed his mind.

> Patient: There's nothing you can do for me. I'm praying to God 15 times a day, and I don't need your help. I don't see why I need to talk to anyone else. So there's no point in talking to you.
>
> Therapist: As long as you're here, you might just as well talk to me anyway. It can't do any harm.
>
> Patient: What am I in for?
>
> Therapist: Don't you know?
>
> Patient: No.

The therapist checked his record and found that the patient had broken

parole by failing to report and by changing his address without notifying his parole officer. He denied it. "That's a lie. I didn't move. I was just walking. For five days I just kept walking. I didn't sleep. I didn't stop or stay anywhere. I was just walking."

When the therapist accepted his statement, he went on. He had been in jail several times. He talked about his previous crimes, mainly thievery. He said he was an alcoholic and had tried Alcoholics Anonymous on his last sentence, but it had not helped. He did not know why he had tried to commit suicide, but "it had just seemed right." The session continued a little longer. The therapist mentioned that it was all right for the patient to have any kind of thoughts, to think anything. After this was discussed for a while, the therapist suggested that the young man come back the next day.

On the second day, he told a little more about himself. He said that he had never felt safe without a gun in his pocket since he was 10 years old, and that he had a gun in his pocket when he was walking the streets before he was arrested this time. He was waiting for the "voices to tell him when to start shooting." He did not know when it would be, but he thought it would likely occur in a bus station. Anyway, the voices would know and would tell him.

He told about his girl. He met her while he was on parole. She had been going out with another parolee, a friend of his. The friend had "slapped her

around," and the patient had intervened. Then he began to go out with her. She induced him to "get a bunch of my friends together, all of us parolees, and beat up the other guy. Now he's got his friends, and the word is out to get me."

The patient was afraid to set foot in the city where his erstwhile friend lived. "They'll kill me. I know those guys, and they don't play games."

Meanwhile, he was having sexual relations with the girl regularly, but he heard that she was seeing the first boy again. When he heard this, he decided that "all my troubles were her fault. I could have gone back to jail, and all my friends too, if they [the police] found out about the fight. All on account of her. So I decided to kill her."

> Patient: I went to a drugstore to get some poison, but they wouldn't sell it to me. So I got an icepick, and I put it in my pocket, and I was going to go to her house and ring the doorbell. And when she answered it, put it right here. [He points to his Adam's apple.] When I got to her house, I rang the doorbell. She opened the door and instead of killing her, I was disgusting.
>
> Therapist: What do you mean?
>
> Patient: I was disgusting. I just did that same dirty old thing.
>
> Therapist: What do you mean?
>
> Patient: You know. I went to bed with her. If I was a man, I would have killed her. I was disgusting.
>
> He was told that he was not disgusting, that the therapist was glad he had not killed her (or anyone else) since, if he had, society would not let the therapist help

him. "But I don't think it was her you really wanted to kill. Wasn't there somebody else you wanted to kill?"

Patient: Who do you mean?

Therapist: Well, it was probably somebody female.

Patient: The other girl.

Therapist: What other girl?

Patient: The last time. The first girl I ever got into bed with. I took her out all the time, and we were going to be married, and then I got arrested. And when I got out of jail, she was married to someone else. I asked one of her friends if she loved him, and she said she'd learn to love him. That seems funny to me.

Therapist: And maybe you were angry at her for leaving you for another man, and when your new girl did the same thing, it was like living it over.

He agreed and said that it might have been the first girl whom he wanted to kill. The therapist then asked him to go back even further.

Therapist: But I think that's still not the whole story. I think there's somebody earlier. Somebody who also left you for another man. And it was easier to kill your girl than to face the idea that you want to kill her.

Patient: That's all there was. There ain't any girl before the first one. Just two of them, that's all.

Therapist: But the girl you really want to kill is your mother. Didn't you ever feel that she left you?

Patient: When the old man came back.

Therapist: Came back?

Patient: He used to take off and just leave her and the kids. He'd take up with some woman or just go off and leave her. And when he was gone, she'd tell me I was the man in the house.

Therapist: And you'd feel like you were married to her.

Patient: Yeah. And then he'd come back. And she'd always take him back.

Therapist: And you were a kid again.

Patient: Yeah. I was nothing when he was around.

Therapist: Then you must have wanted to kill her for that. That's reasonable enough. When first one girl and then the other left you, it was like your mother all over again. And it was your mother you wanted to kill.

The therapist and patient went on to discuss the idea that it was all right for him to want to kill somebody, how all of us want to kill someone when they hurt us, that, in the unconscious, anger is always the wish to kill someone, and that the thought and the feeling are all right.

It was in the third session that he asked about the dream.

Patient: What do you do to get rid of a nightmare?

Therapist: You tell it to me so that we can analyze it.

Patient: Well, I get this dream about once a week, since I was eight. I trip and fall, and then it's like nothing human. I fall, and I don't feel nothing and it's dark, and I get smaller and smaller until there's nothing.

His associations to "trip" and "fall" were the same: falling in the gutter like a drunk, taking codeine, falling down, doing something bad sexually (i.e., heterosexually), getting into trouble with the law, being a homosexual. To

"It's like nothing human," and, "I don't feel nothing," he associated insanity and death. To getting "smaller," he had no associations.

Guessing at the symbolism of getting smaller, the therapist interpreted the dream by pointing out that the patient's associations to tripping and falling were, in fact, all the ways he got into trouble—by getting drunk, taking codeine, getting into trouble with the law, doing something bad sexually, being a homosexual—all of these were his problems. Each was a way of "falling down." Similarly, he had tried to commit suicide and he was going insane, but the dream was a wish and therefore he wanted to fall down. Each of these ways of falling down had a purpose—getting smaller represented a wish to become a child again so he could get the love he wanted but never got from his mother. All of these ways of falling down were ways of proving to himself that he was bad, that his mother was right in not loving him, and that therefore, if he were good, she would have loved him and still might. "But you can't ever stop falling down, or you'll find out she doesn't love you at all, no matter what you do. When you were an infant, you might die if she didn't love you, and therefore you will do anything rather than face that fact."

Not only did the nightmare never recur, but a marked change in pathology occurred at that point. The next day's session began as follows: "Doc, this is crazy. Here I am in jail. I don't know how long I'm in for, at least a year. I'm in with a crew of gorillas. [He had been assigned to the cottage

reserved for the toughest inmates.] Yet I feel freer than I ever felt in my whole life. I'm happier and freer than I've ever been. It's crazy."

He was continued in psychotherapy on a weekly basis after the first week. After the first interval of a week, he said: "You know, it's funny, it's like all my life I've been scared shitless, there was a door closed, and it was bulging at the seams, and I was afraid it would break open. Now the door is wide open. Occasionally something comes out that scares the hell out of me, but I can deal with it. And I'm free. It was worth going to jail for this."

Eventually he was released and found a job. When last heard from, he was looking for a therapist with whom to continue psychotherapy.

Here the connections between symptoms, fantasies, and life events clearly emerge if the therapist does not prevent the patient from talking about his feelings, responds as if everything makes sense although it may be puzzling, accepts murderous thoughts and feelings as normal and meaningful, differentiates thoughts and feelings (which must be understood) from actions (which are the only things that must be controlled), and is aware of the importance of relations with others, of the life history and childhood, and of the unconscious.

In the next example, exploring the meaning of hallucinatory material led to an understanding of significant preverbal traumatic determinants of

schizophrenic illness.

A young woman, diagnosed paranoid schizophrenic, chronic type, with 14 hospitalizations over 10 years, reported the emergence of a persistent visual hallucination of a circle receding away from her. She felt persecuted by the recurrence of the hallucination and by not being able to comprehend it. When the patient and therapist (MT) focused their attention on the image, the patient became aware that it was "a circle within a circle, the inside circle is smaller and darker," receding into the distance. The circle was interpreted as a breast, a breast leaving her. The patient, who did not know the details of her feeding in infancy, asked her mother. Her mother was upset by the question but told her daughter that she had decided to stop breastfeeding because she was uncomfortable with it. She stopped abruptly, but her baby refused to bottle-feed, became increasingly distressed, and was only comforted two days later when, at the urging of her pediatrician (who had been called to deal with the child's "sickness"), the mother resumed breast-feeding. The patient then remembered other situations in which her parents had been unhelpful or unavailable: She was taken to the hospital for a tonsillectomy without prior discussion, and when discharged from the hospital, she was put in her room, where she could hear her parents having a dinner party downstairs, apparently oblivious to her discomfort.

TRAINING

It is essential, first, that the therapist be someone who consciously wants to be helpful to schizophrenic patients, is willing to make a commitment, and is working in a setting that supports such treatment. Therapists who do not want to work in therapy do not keep patients (Karon & VandenBos, 1972; Malan, 1963; May, 1968). In two of the controlled studies in which psychotherapy was reported not to be helpful to schizophrenics, the therapists were told they would not finish their psychiatric residencies unless they "volunteered" (May, 1968; A. Hussain Tuma, personal communication, 1965), or that they would lose their affiliation with a prestigious training hospital if they did not volunteer to treat schizophrenic patients without pay (Grinspoon, Ewalt, & Shader, 1972).

In the Michigan State psychotherapy project (Karon & VandenBos, 1981), the student therapists had the real option of not participating, were paid for their time, and were not required to work with a particular supervisor unless they thought it would be a useful experience.

The second essential quality in a therapist is unconscious motivation. If possible, therapists should be selected on the basis of unconscious motivation. Therapists who were high on unconscious pathogenesis (measured from the TAT)—that is, who tended to meet their own needs when they conflicted with those of dependent others— were not helpful therapists (VandenBos & Karon, 1971).

A third element in therapist training is didactic material. The most important source is the clinical and theoretical section of Karon and VandenBos (1981, pp. 1-369), possibly supplemented by Karon (1984, 1989a, 1992). Useful background readings are Freud's *Introductory Lectures* (1917/1961, 1963; 1933/1964) and his papers on technique (1963), Sullivan (1953a, 1953b), Fairbairn (1954), Guntrip (1969), Fromm-Reichmann (1950), and Malan (1979). This material should be supplemented by any of the many insightful psychodynamic writers who may interest the student. (Every good student will have his or her own interests.)

A fourth element is the observation of tapes or live therapy sessions by an experienced therapist. This is not an absolute necessity, but it provides a model, makes it obvious that patients do respond to intervention, and demystifies the process. Tape review is helpful for showing not only appropriate and useful technique but also the obvious fact that even experienced therapists make mistakes—they don't understand, make wrong interpretations, feel sleepy, have countertransference reactions, and so forth —and still patients get better if most of what is going on is helpful. Thus, psychotherapy with schizophrenics is not magic requiring superhuman therapists, but something any reasonably intelligent, reliably strong, kindly, and well-motivated therapist can learn.

A fifth element of training is supervision. In the Michigan project, early

sessions were observed on videotape or live by other trainees as well as by the supervisor. Live observation can be reassuring to a novice therapist worried about a possibly violent patient. In general, however, supervision is most helpful in the traditional mode of discussing the sessions from the memory and notes of the trainee. When a trainee raises an issue, the comments of the supervisor lead to rapid learning because they solve a problem for the trainee; when something is commented on from a videotape or audiotape, it does not solve a problem for the trainee and does not lead to rapid learning. A videotape may reveal something obvious going on in the patient that the student had not noticed, but most of the subtleties of the interrelationship are far more evident in the awareness of the two participants (and their unconscious reactions) than in the observations of an outside observer. Further, videotaping or audiotaping may make the student therapist anxious or artificial. Notes, as Freud recommended, should be made after and not during the session, because they distract from the therapy. Of course, a trainee may be so out of touch that gross aspects of the session are not noticed, or the trainee may lie about what went on, but such students are probably hopeless in any event. Luckily, such students are rare.

EMPIRICAL EVIDENCE FOR THE APPROACH

The most important study is the Michigan State Psychotherapy Research Project (Karon & VandenBos, 1981) carried out at Detroit

Psychiatric Institute. Twelve sets of three clearly schizophrenic hospitalized patients were selected. Within each set, one patient was randomly assigned to each of three treatments: (1) psychoanalytic psychotherapy without medication, (2) psychotherapy with adjunctive medication, or (3) medication alone as primary treatment. Psychotherapy patients received an average of 70 sessions over a 20-month period.

The medications used were phenothiazines, which were considered the treatment of choice by the majority of the staff of the hospital. For the subset receiving medication as the sole treatment, the patient-physician ratio was held to eight to one for the first weeks of medication (as was usual in that hospital) and then allowed to increase. Specific medication and dosage levels were adjusted for each patient according to the clinical judgment of the treating psychiatrist and his or her supervisor as to the optimal dosage for that patient at that time, varying in accordance with good and routine practice in that hospital. Dosage levels for patients for whom medication was the primary treatment typically were 400 mg of chlorpromazine daily (or its equivalent), varying from a high of 1,400 mg to a low of 100 mg, with most patients receiving between 300 and 600 mg. The dose was decreased somewhat at discharge but was recommended for indefinite use. Interviews were used primarily to adjust medication levels, assess whether discharge or transfer to another hospital was appropriate, and provide minimal support.

For the patients receiving both psychotherapy and medication, the dosage levels tended to be lower, between 100 and 600 mg of chlorpromazine daily (or its equivalent).

Patients in all three treatment groups were blindly evaluated in a series of tests and a thorough clinical status interview (recorded on tape, with possible clues to treatment deleted) before treatment, after 6 months, after 12 months, and after 20 months (end-of-project treatment), whether or not they continued in therapy. All living patients (there were no dropouts) were evaluated at 20 months. The lengths of hospitalizations and rehospitalizations were also recorded. There was a two-year follow-up on hospitalization at all probable hospitals.

Patients were economically poor, of lower socioeconomic status, from the inner city, and predominantly black. While we intended to select acute patients with no prior hospitalizations, repeated evaluations revealed that all the selected patients were chronic and that one-third had been previously hospitalized. Patients and their families routinely lied initially about anything they believed might lead to mistreatment of the patient. (Unfortunately, such lying is *not* irrational.)

Psychoanalytic therapy, compared with medication alone, produced a dramatic improvement in the thought disorder, as well as a more human way

of life in a variety of ways, earlier discharge, and fewer rehospitalizations. The lower rehospitalization rate counterbalanced the initially greater cost of psychoanalytic therapy, which in the end was considerably less expensive over the four-year period. Two-thirds of the patients who received only medication had to be rehospitalized in the follow-up period, whereas only one-third of those who had received psychotherapy, with or without medication, had to be rehospitalized. Three-fourths of the medication-only patients received welfare in the follow-up, compared with only one-third of the psychotherapy patients.

Most effective was psychotherapy without medication, or with medication that was reduced as rapidly as the patient could tolerate it. Psychotherapy with medication that was maintained was not as effective, but more effective than medication alone. Future ability to avoid hospitalization was best predicted by improvement in the thought disorder, not by length of initial hospitalization.

Experienced therapists were more effective, as were more emotionally mature and responsible therapists and those who had low pathogenesis (TAT) scores.

Three frequently cited American studies seemed to find that psychotherapy has little to offer schizophrenic patients, but the Philadelphia

study (Bookhammer, Myers, Schober, & Piotorowski, 1966) used a psychotherapy that bore no relationship (Brody, 1959) to the therapy described in the theoretical and clinical papers on which it was supposedly based (Rosen, 1953); the California study (May 1968) used therapists with no relevant training or experience supervised by supervisors with no relevant training and experience (Wexler, 1975); and most of the "experienced" therapists in the Boston study were unfamiliar with working with these kinds of patients, and half resented "volunteering" to work without pay (Grinspoon, Ewalt, & Shader, 1972).

A survey of all available empirical studies with control groups (Karon, 1989b) showed considerable evidence that a variety of psychosocial treatments are effective. Thus, a modified Rogerian approach (Rogers, Gendlin, Kiesler, & Truax, 1967), particularly if the therapists are warm, genuine, and empathic, and a behavioral approach (Paul & Lentz, 1977) were demonstrated to be helpful. Soteria House, a therapeutic milieu, was demonstrated to be more helpful to nonmedicated first-break young schizophrenics than treatment with medication (Matthews, Roper, Mosher, & Menn, 1979). Deikman and Whitaker (1979) found that a ward using psychological treatment without medication (for 11 months) resulted in fewer rehospitalizations and no suicides, suicide attempts, or elopements. (The comparison medication ward had three suicides.) In Austria, Schindler (1980) found that patients treated with "bifocal family therapy" fared far

better than those treated with medication in a 10-year follow-up. In Sweden, Sjostrom and Sandin (1981) found that patients treated with psychodynamic therapy and lowered medication did better than controls treated with medication.

Revere, Rodeffer, Dawson, & Bigelow (1981) found that "warm intrusive therapy" (their form of psychodynamic group therapy, based on ideas similar to those of this chapter) was more helpful to chronically institutionalized (average of 15 years) schizophrenics than medication alone. Five out of seven psychotherapy patients obtained employment or were discharged or both and also improved on clinical measures. No such improvement occurred in the medicated controls.

Teixeira (1982a) found that a psychodynamic day treatment program was helpful on a number of measures, but he had appropriate comparison group data only on some outcome variables on patients treated in other kinds of day treatment programs. In Finland's community mental health system, Alanen (1991; Alanen, Rakkolainen, Laakso, Rasimus, & Kaljonen, 1986) demonstrated empirically that increasing the availability of inpidual and family therapy greatly improved the outcomes, especially long-term outcomes, as compared with earlier (medication) results.

Of course, a wealth of case studies and clinical experience exists, as well

as studies without control groups, but they are less scientifically convincing. For example, Benedetti and Furlan (1987) reported from Italy and Switzerland a series of 50 severe cases treated with intensive psychoanalytic therapy (two to five sessions per week) for three to ten years by supervisees, with very good outcomes in 80% of the cases.

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