Healing (Sometimes Curative) Psychotherapy of Schizophrenia and Other Psychoses

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JUNG--VIEWS ON PSYCHOSIS:

"Though this be madness, yet there is method in it."
Shakespeare

- "Whereas the neurotic can rely instinctively on his personality dissociation never losing its systematic character, so that the unity and inner cohesion of the whole are never seriously jeopardized, the latent schizophrenic must always reckon with the possibility that his very foundations will give way somewhere, that an irretrievable disintegration will set in, that his ideas and concepts will lose their cohesion and their connection with other spheres of association and with the environment. As a result, he feels threatened by an uncontrollable chaos of chance happenings. He stands on treacherous ground, and very often he knows it. The dangerousness of his situation often shows itself in terrifying dreams of cosmic catastrophes, of the end of the world and such things. Or the ground he stands on begins to heave, the walls bend and bulge, the solid earth turns to water, a storm carries him up into the air, all his relatives are dead, etc. These images bear witness to a fundamental disturbance of relationship, that is, of the patient's rapport with his surroundings, and graphically illustrate the isolation that menaces him" (Jung, 1958, pp. 258-259).

JUNG--VIEWS ON PSYCHOSIS

- "When we penetrate into the human secrets of our patients, the madness discloses the system upon which it is based, and we recognize insanity to be simply an unusual reaction… to emotional problems which are in no way foreign to ourselves" (Jung, 1914).
- "More than once I have seen that even with such patients there remains in the background a personality which must be called normal. It stands looking on, so to speak...Through my work with patients I realized that paranoid ideas and hallucinations contain a gem of meaning" (Jung, 1909).

VIEWS ON PSYCHOSIS

- "Why is the mind compelled to expend itself in the elaboration of pathological nonsense?...Today we can assert that the pathological ideas dominate the interests of the patient so completely because they are derived from the most important questions that occupied him when he was normal. In other words, what in insanity is now an incomprehensible jumble of symptoms was once a vital field of interest to the normal personality" (Jung, 1914).
- "The therapeutic task is to help the individual take his illness seriously and turn it into a challenge… a psychotic individual should have the right to discover whether or not his illness can become a true journey of the self" (Eigen, 1986).

PSYCHOSIS AND TRAUMA

- "The most probable explanation of the relationships between trauma and psychosis is that **some psychotic patients will develop PTSD in response to their psychosis, some people will develop psychosis** in the first place **as a result of traumatic experiences, some** may **develop both,** and for **some people a vicious circle** may develop **between their psychotic experiences and their PTSD symptoms.** It is also possible that some shared mechanism (such as dissociation, attributional style or interpretations of intrusions) may be responsible for mediating the development or maintenance of the disorders" (Morrison, Frame, & Larkin, 2003).

PTSD EMERGES FROM PSYCHOSIS

- **Acute psychosis and psychiatric hospitalization may be sufficiently traumatic to precipitate PTSD** (Lundy, 1992; McGorry *et al.*, 1991; Shaner & Eth, 1989; Shaw, McFarlane, & Bookless, 1997; Williams-Keeler *et al.*, 1994; McGorry *et al.,* 1991, Meyer *et al.* 1999).
- **Many** studies find a substantial rate of people with psychosis **develop PTSD in response to their psychotic experiences** and/or their **hospital treatment** (Morrison, Frame, & Larkin, 2003).
- **High rates of traumas among psychotic populations** (Ellason & Ross, 1997; Read, 1997; Goff *et al.*, 1991; Masters, 1995; Mueser *et al.*, 1998; Ross & Joshi, 1992) with **many experiencing trauma prior to the onset of their psychosis** (Honing, 1988; Stampfer, 1990).
- Study: first-admission **people with psychotic disorders** (*n* = 426), found **lifetime prevalence of trauma exposure was 68.5%** and **26.5% met PTSD criteria** (Neria, Bromet, Sievers, Lavelle, & Fochtmann, 2002).

PSYCHOSIS EMERGES FROM PTSD

- **Two pathways** to schizophrenia: an **endogenously driven** pathway with **negative symptoms** and a **pathway** determined **by childhood trauma** with predominance of **positive symptoms**.
  - Onset of **auditory hallucinations** was **preceded** by a **traumatic event** or an event that activated the memory of earlier trauma (Honig *et al.*, 1998).
  - 70% of people with auditory hallucinations developed them following a traumatic event as part of a coping process (Romme & Escher, 1989).
  - The **trauma** may function as a **stressor** in a **stress-vulnerability model** precipitating the onset of schizophrenia (Zubin and Spring, 1977; Goodman *et al.,* 1997).

PSYCHOSIS EMERGES FROM PTSD

- Speculation regarding **traumatic life events** and **development of psychosis**; particularly **childhood sexual abuse (CSA), physical abuse, or interpersonal violence**.
  - Beck and van der Kolk (1987) found 46% of 26 chronic, hospitalized patients with a psychotic disorder reported incest.
  - Friedman and Harrison (1994) found that 60% of 20 patients with a diagnosis of schizophrenia had experienced CSA.
  - 56% of patients admitted for first-episode psychosis reported CSA (Greenfield Stratowski, Tohen, Batson, & Kolbrener, 1994).
  - 53% of patients with severe mental illness report CSA or physical abuse (Darvez-Bamez, Lemperiere, Degiovanni, & Gaillard, 1995; Goff *et al.*, 1991; Ross, Anderson, & Clark, 1994).
  - Read *et al.* (2002) found that hallucinations, especially commenting voices and command hallucinations were significantly related to sexual abuse and childhood physical abuse in a sample of 200 community patients.

PSYCHOSIS EMERGES FROM PTSD

- "**Obsessional psychosis**," proposed subtype of schizophrenia that includes **repetitive and distressing hallucinations associated with trau**ma... (Kingdon & Turkington, p. 69).
- **Consistent structural and chemical changes** In the **brains of patients with** a diagnosis of **schizophrenia** and those associated with **trauma**. Supports "Traumagenic neurodevelopmental model of schizophrenia." (Read, Perry, Moskowitz, & Connolly, 2001; Read, et al, 2001; Turkington, 1999; Stein *et al.*, 1997).
- Patients with a **diagnosis of schizophrenia** exhibited **higher dissociative phenomena** which were significantly **associated** with **hallucinations and delusions** and greater vulnerability to psychotic experience (Spitzer, Haug, and Freyberger, 1997; Allen *et al.*, 1997, p. 332) .

PSYCHOSIS EMERGES FROM PTSD

- Developmental stage of the trauma could influence how the traumatic memory is encoded or stored. **Earlier onset of trauma** may yield **increasingly incoherent and fragmented memories** that are at **greater risk** of becoming distorted, elaborated, and **disconnected from the traumatic event.** The individual may be more likely to **experience that retrieval as psychotic hallucinations** (**and be diagnosed accordingly**) as **opposed to** an **intrusive recollection** of **trauma** (Bremner & Narayan, 1998) .

PRENATAL STRESS, TRAUMA, AND PSYCHOSIS:

- "…**stress during gestation** can induce **long-lasting behavioral changes** in the offspring, characterized by a decreased ability to cope with…stressful situations…**dysregulation** of the **HPA axis** [limbic-hypothalamic-pituitary-adrenal]...can affect the developing fetal brain at a critical time…" (Weinstock, M., 1998).
- **Schizophrenia correlated** with **maternal prenatal stress**: maternal starvation (Susser & Lin, 1992); prenatal death of father (Kuh & Ben-Sholomo 1997; Huttunen & Niskanen 1978); unwanted pregnancy (Myhrman et al. 1996); war--attack on Nagasaki (Koenig et al. 2002); invasion by Nazis (van Os & Selten 1998).
- **Elevated** rates of **schizophrenia** are **related to maternal depression** during pregnancy which is often associated with hypercortisolemia (Jones et al. 1998).

PSYCHOTIC DEVELOPMENT AND ADAPTATION

- The **repudiation of subjective reality** is linked to the existence of **psychotic states** (Stolorow & Atwood, 1987).
- Individuals who operate on a **psychotic level of development** have a **preverbal** and **pre-relational level** of relating and development characterized by **merger and symbiosis** (may seem strangely unrelated and merged).
- "**Withdrawal into fantasy** constitutes a **dissociation** from **psychic reality** and the **emergence of the delusional world** which constitutes the adult illness. Dissociation..is ignored or unknowingly encouraged. Children enter dissociated world as a defense but also to achieve…delusional self-sufficiency…" (DeMasi, 2009).

PSYCHOTIC PROCESS

- **Attacks** on linking processes **ensure** the **collapse of meaning** (Bion, 1959)
- "Deathification:" **attacks** are made on **links between thoughts, thoughts** and **feelings** or **among thoughts, feelings, actions**.
- **Anti-learning** and **anti-contact** attitude. Mind slips into a state of nonexistence. Attempts a **process of simplification** to control, **de-animate** everything and reduce all to deadness.
  - Work with psychotics is demanding, oscillating between being withdrawn and cut-off to clinging and demanding. Needs for others can be nonexistent or all consuming (Jung, 1909).

THERAPEUTIC CONSIDERATIONS WITH PSYCHOTIC MATERIAL

- **Strive to comprehend the patient's phenomenological experience and subjective truth**. Psychotic material is often illogical, confusing; regarded as meaningless and bizarre. It can engender countertransference reactions of despair, fear, anxiety, apathy, boredom and anger. Even if "meaningless," the patient's development is assisted by having the experience of being heard.
- **Promote safety**. Individuals who suffer from psychoses often operate from a place of terror and fear. Safety can be increased by establishing a predictable rhythm. Affirming their subjectivity can be vital for trust and rapport. Affirmation is not agreement.
- **Do not necessarily establish a "warm" therapeutic relationship immediately**. "Loving," "warm," or "affectionate" feelings may not be trusted and may engender anxiety, fear, or paranoia. Reassurance or premature efforts to assuage anxiety may be regarded suspiciously and be counterproductive.
- **Do not "work" for the patient's positive regard nor effusively express unconditional positive regard**. Inform the patient they will come to a more complete understanding of you through their lived experience of you and your work together. This may decrease mistrust and promotes reality testing.

THERAPEUTIC CONSIDERATIONS WITH PSYCHOTIC MATERIAL

- **Monitor the level of stimulation.** Frequently, individuals with psychoses are hypersensitive and suffer from being flooded with stimulation. They may have deficits in regulating the flow of stimulation. More "active" behaviors in therapy — interpretations, feedback, instruction, proscription or advice--may be experienced as overstimulating, frightening or intrusive and be met with "resistance" in the form of noncompliance and angry or fearful withdrawal.
- **Strive to understand the delusion**. Be careful not to reject a patient's belief because it is unusual and outside your realm of experience. Learn more about their belief and make a concerted effort to actively evaluate his/her belief in the context of your relationship. This models the process of systematic analytical thought and displays respect for one's internal world.

THERAPEUTIC CONSIDERATIONS WITH PSYCHOTIC MATERIAL

- **Monitor the patient's desired level of active, interpersonal relatedness**. Closeness, space and distance may be experienced differently. "Normal" levels of connectedness and communication may feel uncomfortable. A psychotic patient's withdrawal may be modeling the degree of relatedness they are currently desiring or needing from you. Sitting in silence may be soothing.
- **Explore hallucinations and delusions**. Discussing psychotic productions can be therapeutic when approached in a contained way. Creating a space where the patient can describe dimensions of what he/she hears or sees can be healing and increase treatment compliance. Framing this production as being, "like a dream" can increase their comfort with these symptoms.
- **Find the kernel of "truth" in hallucinations and delusions**. Transferential themes, developmental experiences, and trauma are interlaced in hallucinations and delusions, just like other verbalizations in therapy. Taking this stance does not mean these events have caused the hallucination or delusion but recognizes their association with life experiences and engages the patient in treatment. Understanding the vector of "truth" is a starting point for constructing its meaning in the context of the person's life. What are the different symbolic meanings for the delusional content? What salient developmental themes may be represented in this material?

THERAPEUTIC CONSIDERATIONS WITH PSYCHOTIC MATERIAL

- **Address resistances to talking about their inner experience (including hallucinations and delusions)**. Individuals are frequently ashamed or scared of their inner world, hallucinations, and delusions. Validating shame or fear can help promote conditions of safety and trust necessary for discussing and making meaning of their internal world. (i.e. "Talking about yourself may be hard given how fearful/bizarre/threatening your voices/ideas/images are.")
- **Learn the language of symbol, imagery and metaphor**. Individuals with psychosis frequently speak in this "language" as it condenses much information into a single word, phrase or image and is not readily discernable. It is often felt as "safer" to express. Understanding the personal and collective meanings of symbols and metaphors may improve treatment. Speaking in this language develops a relationship with the patient. It does not necessarily mean that you interpret the meaning of a symbol to the patient.
- **Maintain an open and accepting, yet, non-affirming and testing attitude toward delusional material.** In working with delusions, consider adopting an attitude where you continually examine the evidence. Consider telling the patient you must suspend judgment until you have sufficient evidence.

THERAPEUTIC CONSIDERATIONS WITH PSYCHOTIC MATERIAL

- **Develop an understanding of the delusion through the patient's associations, life themes and developmental history**. Delusional material can contain some important, primary, developmental theme. Working on these developmental issues can depotentiate its strength. As work is done with the developmental injury and trauma, consider linking developmental material with the delusions.
- **Strengthen areas that are more intact and which have better capacities for reality testing.** Buttress ego deficits by appealing to more cohesive areas of ego strength. Psychotics, like all individuals, are more likely to have deficits around material that is more affect laden, conflictual, and anxiety provoking.
- **Target inconsistencies in delusions.** Inconsistencies emerge once the patient verbalizes his/her delusions. Highlighting and questioning these inconsistencies even if the patient refutes or rationalizes them, is the first step in recognizing incompatible elements. This is different from confronting, refuting, debating, or asserting one's own views.

THERAPEUTIC CONSIDERATIONS WITH PSYCHOTIC MATERIAL

- **Recognize when fantasy material is about play and not reality testing**. Psychotic individuals can have playful fantasies, just like nonpsychotic individuals. Engaging with their playful fantasies is a way to develop symbolic representation and allow the healthy emergence of psychological material.
- **Desist pressures to confirm the veridicality of a delusion**. If a patient asks if a delusion is true consider responding, "there is no way that I could know if that is true—could you tell me more about it?" This preserves trust, models respect for their subjectivity, avoids an, often, losing battle and allows the symbolization of delusional material.
- **Assist with differentiation and boundary formation**. Individuals with psychoses often have difficulties discerning inside from outside; self vs. other. Be sensitive to patient's inaccurate perceptions of distance or merger and work to correct misperceptions (e.g. your failure to greet your patient in the cafeteria did not mean you wanted to kill him; your sneeze does not mean the patient has a cold or made you ill). Identifying what is yours versus what is the patient's assists with differentiation. Boundary formation is further solidified by attention to the boundaries in your therapeutic relationship.

THERAPEUTIC CONSIDERATIONS WITH PSYCHOTIC MATERIAL

- **Problems with distinguishing fantasy from reality are often related to difficulties with differentiation.** Attention to the process of bizarre material may be just as important, if not more important, as the content. Help to identify this process by making a "process" comment during therapy (i.e. "you are currently describing a scene that is taking place in your head—a fantasy—and not something that happened to you today—that is, reality, to me").
- **Stabilize boundary between inside experience and outside experience partially by creating boundaries and structure**. Pointing out when the individual is describing a fantasy versus a real life event; a feeling versus an action; and an experience with them versus an experience with you helps to develop boundaries. (i.e. "In your fantasy you are killing your mother but in reality she is still alive"; "you are describing feeling murderously angry which is different from actually killing someone which you have never done before").
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HEALING EXPRIENCES: ELYN SAKS

THE CENTER CANNOT HOLD: MEMOIR OF SCHIZOPHRENIA

- "It's also a place where you can bring your thoughts,… A lot of therapists have a rule where their patients cannot articulate their delusions or hallucinations — but to me you need to have a place where you can do that, where it's safe. It's sort of like a steam valve. I don't have to do it in my outside world, I have a place where I can do it in therapy.… Insight is valuable."
- "Exaggerated ideations are a defense—making a person feel better or safe."
- "People have different theories about psychotic symptoms… Some people think they're just the random firing of neurons that don't have any meaning. But I think they have meaning and that they tell you some truth about your psychological reality. So, when I say I've killed hundreds of thousands of people, it's really an archaic way of saying I feel like a very bad person. But even though it's meaningful in this sense, it doesn't help patients in the moment of the psychotic symptoms that they interpret."

ELYN SAKS

- "Her tolerance and understanding seemed endless, and her steady calm presence contained me, as if she were the glue that held me together. I was falling apart, flying apart, exploding – and she gathered my pieces and held them for me" (Saks, 2008).
- "While medication had kept me alive, it had been psychoanalysis that helped me find a life worth living"
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TRANSFORMING MADNESS: NEW LIVES FOR PEOPLE LIVING WITH MENTAL ILLNESS--JAY NEUGEBOREN

- "The question, then: why did the medication that worked so well—so miraculously—on Monday stop working on Tuesday? The answer: because Robert was deprived of a relationship that had been a crucial element in his recovery."
- "I was interviewing hundreds of former mental patients for a book I was writing they were people who had been institutionalized, often for 10 or more years, and who had recovered into full lives: doctors, lawyers, teachers, custodians, social workers. What had made the difference?"
- From: Newsweek, My Turn, "Meds Alone Couldn't Bring Robert Back," by Jay Neugeboren, Feb. 6, 2006.
- http://manitoba.cmha.ca/files/2012/03/MyTurn-MedsAloneCouldntBringRobertBack.pdf

TRANSFORMING MADNESS: NEW LIVES FOR PEOPLE LIVING WITH MENTAL ILLNESS--JAY NEUGEBOREN

- "Some pointed to new medications, some to old; some said they had found God; some attributed their transformation to a particular program, but no matter what else they named, they all —**every last one—said that a key element was a relationship with a human being**. Most of the time, this human being was a professional—a social worker, a nurse, a doctor. Sometimes it was a clergyman or family member. In every instance, though, it was **the presence in their lives of an individual who said, in effect, "I believe in your ability to recover, and I am going to stay with you until you do" that brought them back**. So it was with my brother, who, through his **daily collaboration with Alan** and the **dedication of Dr. Pam** (who refused to go along with the staff consensus that Robert would never live on his own) **has not had a single recurrence for more than six years**, the longest stretch in his adult life. "
- From: Newsweek, My Turn, "Meds Alone Couldn't Bring Robert Back," by Jay Neugeboren, Feb. 6, 2006.

TRANSFORMING MADNESS: NEW LIVES FOR PEOPLE LIVING WITH MENTAL ILLNESS--JAY NEUGEBOREN

- "…I too have witnessed **hundreds of formerly homeless**, mentally ill adults **renew their lives not only through** access to a wide range of **medications, but through access to individuals** like Jim and Dr. Pam, who believe that pills, while useful, are only a small part of the story, and that **the more we emphasize medications as key to recovery, the more we overlook** what is at least as important: **people working with people, on a sustained long-term basis**."
- "Let's find resources to give people afflicted with mental illness what all of us need: fellow human beings upon whom we can depend to help us through our dark times and, once through, to emerge into gloriously imperfect lives."
- From: Newsweek, My Turn, "Meds Alone Couldn't Bring Robert Back," by Jay Neugeboren, Feb. 6, 2006.

HEALING FROM PSYCHOSIS: FRIEDA FROMM REICHMANN

- "*My experience during the last twenty years has been mainly with schizophrenic patients who came to our hospital in a state of severe psychotic disturbance… the majority emerged sooner or later under intensive dynamic psychotherapy… they continued treatment with the same psychiatrist through the years of their outwardly more quiet state of illness, with the aim of ultimate recovery with insight… the patients were seen for four to six regularly scheduled interviews per week… Sometimes relapses occurred… due to failure in therapeutic skill and evaluation of the extent of the patient's endurance for psychotherapy, to unrecognized difficulties in the doctor-patient relationship… these relapses could be handled successfully if the psychiatrist himself did not become too frightened, too discouraged, or too narcissistically hurt by their occurrence*" (Bullard, p. 196)