# DIFFICULTIES IN PSYCHOTHERAPY WITH A RESIDUAL SCHIZOPHRENIC

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For my dearest friends Adi and Charmaine who, so sadly, could not wait for me to finish.....

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## ABSTRACT

This work addresses some of the difficulties encountered while working in psychotherapy with a residual schizophrenic.

While there is an abundance of literature on psychotherapy for schizophrenia, both supporting and also refuting its merit, what the literature fails to reveal is that there appears to be a class of schizophrenic who, while apsychotic and able to communicate in the everyday sense of the word, is in a psychic space which speaks of a break with the basic relational elements of the human order. The quality of the patient's psychic life is such that almost nothing of what the literature describes as useful and appropriate in working with schizophrenics seems to help in the psychotherapeutic work with this type of patient. This study describes these issues with relevance to a particular residual schizophrenic.

The Illustrative-didactic case-study method was used to discuss the four-and-a-half month psychotherapy with this patient. The patient's early developmental history, premorbid personality functioning, family and interpersonal relationships, mental state, diagnosis and a rationale for psychotherapy were presented and considered in detail. The structure of the psychotherapeutic process was reviewed in depth. The hermeneutic guidelines to understanding the case were drawn from Object-Relations Psychoanalytic theory, particularly Balint, Khan, Karon & VandenBos, Bollas, Romanyshyn, Perry, Symington, Fordham and others.

Various psychic and personality features, as unveiled through the psychotherapeutic process, were elaborated and the implications of these for the therapeutic endeavour were considered as follows:
Firstly, the psychic space of the patient, which precluded mirroring, symbolization and object-relationship - and which made psychotherapy untenable, was discussed. Secondly, therapeutic ambivalence and other counter-transference issues were reviewed. Thirdly, the shadow sides of both therapeutic optimism and of psychotherapeutic change were considered. Fourthly, the issues of therapeutic failure and of other treatment possibilities for a residual schizophrenic patient were examined.

It was concluded that there needs to be an important countertransference shift with regard to the psychotherapeutic goals for those patients whose condition may be chronic, and for whom it appears that psychotherapy is

not going to be of any therapeutic benefit - and where an 'empathic accompaniment' might be as much as it is possible to hope for or achieve.

# CHAPTER 1

## 1.0 Aims of the Project and Rationale

The aim of this project is an attempt at illustration of some of the difficulties encountered while working in psychotherapy with a residual schizophrenic. While many clinicians would undoubtedly shrug their shoulders or, at the very least raise an eyebrow at an undertaking of this nature, and most especially by a training psychotherapist, there is also ample support for such a venture. Among these protagonists are clinicians of extremely high repute in their fields, such as Karon, VandenBos, and Perry, to name but a few.

What the literature fails to reveal, however, and what is also the aim of this project, is that there appears to be a class of schizophrenic who, while apsychotic and able to communicate in the everyday sense of the word, is in a psychic space which speaks of a break - not with reality, but somehow with the human world and, more specifically, with the basic relational elements of the human order. The quality of the patient's experience and his interpersonal and psychic life appears such that nothing, or almost nothing of what the literature described as helpful and appropriate in working with schizophrenics made any real sense, or more importantly, any real difference in the psychotherapeutic work with a schizophrenic patient.

Some of the questions I will attempt to address in this paper are the following :

What are the missing relational elements that make psychotherapy in some cases of schizophrenia, untenable ie., is there some kind of break with the human order? What then, if this is so, can the psychotherapist possibly hope to achieve? Or, if it not so, is it rather a breakdown in imagination, or in the symbolic order? Does therapeutic optimism, considered essential for psychotherapy with schizophrenia (eg., Karon & VandenBos,1981), become a kind of grandiosity? Should the fact that the patient supposedly did not benefit from psychotherapy lead the therapist to consider a therapeutic failure in all respects? What, if any, other possibilities might there be for such a patient? Further, an important question regarding the value of psychotherapy with a residual schizophrenic as opposed to someone who enters psychotherapy in an acute psychotic state will be raised ie., is overt 'craziness' or psychosis necessary, at least at the beginning, for a successful psychotherapy?

It is hoped, through some of what I will reveal about the nature of my work with a residual schizophrenic, that my experience will be illuminated in a way which will perhaps be useful for others attempting a similar task - and also perhaps help to situate it better for myself.

Given that these are some of the aims and questions which will be addressed, it was felt that the case-study method would be the most appropriate manner in which to do so. As such, examples and verbatim transcripts will be used to illustrate the nature of the psychotherapy, the therapeutic relationship, the quality of the patient's psychic space and the implications of these for the psychotherapeutic work.

A preliminary review of some of the relevant literature on psychotherapy as treatment for schizophrenia, encompassing research studies on the effectiveness of psychotherapy as well as various treatment perspectives, will be presented below.

# CHAPTER 2

## 2.0 Literature Survey

## 2.1 Theoretical Perspectives

Theoretical perspectives on the origins, development, process, treatment and prognosis of schizophrenia are probably as many and varied as there are theorists, and while no text could really be complete without mention of at least some of these, it is not my intention to review the extensive literature on the subject, but merely to outline some of the work and views of a few of the writers following the more analytic tradition. I shall therefore limit my discussion of the literature in this section to the works of Karon & VandenBos, with particular focus on treatment or therapeutic issues rather than etiological or developmental considerations, except where these pertain specifically to the case study which will be presented below. In later sections, and particularly as I work through the main discussion section (Chapter 6), I will include many references to the works of Bollas, Balint, Khan, Gendlin, Stein, Romanyshyn, Plaut, Green, Symington, Perry, Redfearn, Fordham, Gordon and others.

I have made the assumption that the available literature on psychotherapy for schizophrenia is relevant, since the classification of 'residual phase' falls under the broad schizophrenic diagnostic classification. The diagnostic criteria will be discussed in Chapter 4 below.

I would like to begin the literature survey on psychotherapy for schizophrenia by presenting some compelling research studies.

## 2.2 Research Studies

In their book, Psychotherapy of Schizophrenia : the Treatment of Choice, Karon & VandenBos (1981),[1] include a chapter in which they outline what they term the six major empirical studies which have been done since 1960 to assess the effectiveness of psychotherapy with schizophrenics. These are: the Pennsylvania study (Bookhammer et al.,1966); the Wisconsin project (Rogers et al., 1967); the California project (May,1968); the Massachusetts project (Grinspoon, Ewalt & Shader,1972); the Illinois project (Paul & Lentz, 1977 - a psychosocial approach which I will omit)

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1. All references to Karon & VandenBos are from the above mentioned book ie., (1981) and this date reference will not necessarily be repeated.

and the Michigan State University project - which was conducted by the authors. These research studies will outlined very briefly below.

The Pennsylvania study (Bookhammer et al.,1966), is described as important mostly in that it was the first to attempt to rigorously evaluate psychotherapy for schizophrenia. Results showed insignificant differences between patients receiving 'direct analysis' (a psychoanalytic type of psychotherapy) and those who received only routine hospital treatment. This study is severly criticised for its sloppiness generally, and the discrepancy between the psychotherapeutic techniques described - and those used, which, according to Karon & VandenBos, obscured the scientific significance of the study.

The second, the Wisconsin project (Rogers et al.1967; Karon & VandenBos), showed a positive relationship between psychotherapy for schizophrenia and outcome, and highlights the importance of the quality of the therapeutic relationship. Although the researchers reportedly used more adequate controls, Karon & VandenBos say that the results were contaminated by the fact that some of the control patients were also in group-therapy, and some of the experimental patients also received medication. Their contribution, however, was in clarifying 'the complexity of doing meaningful research with any degree of rigour, and the complexity of the therapeutic relationship'.

The third, the California project, is one where May (1968) describes a five treatment groups project that was conducted on 228 schizophrenic patients who were considered to be in the middle third of the prognostic range. The five treatment methods were; i)individual psychotherapy alone, ii)medication alone, iii)individual psychotherapy plus medication, iv) electroshock treatment (ECT), and v)milieu therapy- a control group who received none of the above specific treatments. Each form of treatment was considered to have been given 'a fair trial under good realistic conditions in suitable dosage for an adequate length of time' (May, 1968. p. 57) - ie., until the patient had made successful recovery, or the treatment had been given for 6-12 months, and both the supervisor and the therapist considered it a failure. Psychotherapy time ranged from 7-87 hours with a mean of 49 hours. *Psychotherapy alone* and *Milieu* were considered the least effective treatments and the effectiveness of *ECT* was said to be somewhere between these two. May found only a very slight but, in fact, a positive interaction between *drug* and *psychotherapy*. May's conclusions advocate medication as the treatment of choice. Karon & VandenBos criticise the study on many issues - to name a few; the 'quality' of the psychotherapy and the supervision, methods of collecting outcome

measures, the attention paid to 'cost effectiveness' of medication for ward adjustment - versus adjustment in the real world, and the trivialisation of improvements such as better insight, for example.

The Massachusetts project (Grinspoon at al.,1972) is seen by Karon & VandenBos as being experimentally unsound, and is often quoted as evidence that even experienced therapists are ineffective with schizophrenia. Results from this study rated medication as slightly better on outcome measures than placebo treatment, and psychotherapy was found to be ineffective. However, Karon & VandenBos note that the therapists were not experienced with schizophrenics per se, were not paid for their services, were not experienced with the resistances found in lower socioeconomic patient groups, and that those who were experienced with schizophrenics felt that the frequency of psychotherapy (twice a week) was insufficient. They also state that the patient group was unsuitable, as eleven of the twenty patients had received either ECT or insulin coma treatment, or both.

The focus of the research presented by Karon & VandenBos is the Michigan State University project (1966-67) undertaken by the authors. They used a small sample of 36 patients. Three treatments were devised; Group A had a psychoanalytic psychotherapy without medication - (5 times a week for the first 5 weeks and once a week thereafter); group B had an 'ego-analytic psychotherapy' plus medication (psychotherapy 3 times per week for at least 20 sessions and then reduced to once a week); the C group, or control group, received medication as the primary treatment. Six, twelve and twenty month evaluations were done regardless of discharge. Outcome measures included the WAIS, TAT, Rorschach and Clinical Status Interviews, ie., intellectual, personality (or quantitative data) and also clinical data. Measures of the effectiveness of psychotherapy were divided into four groups and considered - the length of hospitalisation, a clinical evaluation of functioning, direct measures of thought disorder and projective tests.

On all but the projective tests both psychotherapy groups did significantly better than the control group. On a two year follow-up it was found that the psychotherapy patients had an average of 56.4 days of hospitalisation, and the 'controls' had 99.8 days of hospitalisation during the 2-year period after treatment, ie., the psychotherapy patients spent 'roughly half as much time' back in hospital as those who had not received psychotherapy. It was also noted that patients who did not receive psychotherapy had a 2:1 chance of being rehospitalised and those who had received psychotherapy, a 2:1 likelihood that they would not (p.437). Ie., 67% of the *medicatior*

*alone* patients were rehospitalised; 22% of the *psychotherapy alone*; and 42% of the *medication plus psychotherapy* patients were rehospitalised. The authors outline many conditions, however, pertaining to *relevant* psychotherapy, training, experience, knowledge, and motivation of psychotherapists, and state that these are critical to their findings. They also raise the question of therapist experience and conclude that experienced therapists, (those with 10 years experience with schizophrenics) were better able to help, ie., in a shorter time and at less cost eventually, but that inexperienced therapists nevertheless achieved comparable results.

The results of the studies described above are clearly conflictual and range from total support to total refutation of the value of psychotherapy for schizophrenia. Those which support psychotherapy are well documented, convincing and inspiring - and the effectiveness of psychotherapy for schizophrenia appeared to be of enough consequence to encourage me to undertake psychotherapy with a schizophrenic patient.

## 2.3 Treatment Perspectives

There are a great many methods described in the literature on treatment for schizophrenics and these range from drug, through ECT to psychotherapy with various approaches within and between these which are too numerous to describe (and clearly beyond the scope of this project). Since Karon and VandenBos were my main source of inspiration, I will outline some of the recommendations for psychotherapy with schizophenics which they propose.

NOTE: Although I am also aware of an abundance of family approaches, among which can be found such eminent writers as Lidz (1973), Palazzoli et al.,(1980) etc., and the recent gravitation towards these approaches- and the respect shown them, again, a discussion of these is untenable in terms of the limited scope of this project. I would like to add that in terms of considering a family approach with the patient described below, it was felt that this would not be feasible for the following reasons: Firstly, the family, or, most specifically the patient's mother, has what might loosely be termed 'fanatical' religious convictions and a belief that the devil had contaminated her son in some way, and that in order to get well he had to be 'reborn'. Brooke (1989), sees Fundamentalist beliefs as a contraindication for psychotherapeutic work and it seemed highly likely that religious differences within the family, especially between the patient and his mother, would make such work impossible. Secondly, it was felt that the main thrust for the patient was to function outside of,

rather than within the family, since he had already left home five years previously.

### 2.3.1 Karon & VandenBos - A Psychoanalytic Perspective

Karon and VandenBos outline a psychoanalytic psychotherapy for schizophrenia. Broadly, the task of psychotherapy is 'to untangle the past from the present and to make the future conceivable' - and to separate and deal with both reality and fantasy. They emphasize the role of affect as central to every psychotherapy and focus on anger, despair, loneliness, terror and shame. They address the therapist activity/passivity question as secondary to what action to take to be helpful, when to take it, and when not. They consider regression inevitable - and to the question of accepting or limiting the regression, they suggest that the therapist 'do what is necessary (ie., unavoidable) or most helpful to a particular patient at a particular time'.

Those aspects of psychoanalytic theory which they embrace are 'ideas about the conscious and the unconscious, the relationship of childhood to adulthood, symbolism, displacement and defense mechanisms' (p.139).
Some of the psychotherapeutic insights gleaned through their work with schizophrenic patients will be presented below.

1. The patient will not communicate clearly with the therapist, even as to whether the psychotherapy is helpful - he dares not as he is afraid it will be used against him. Therefore, the therapist must be prepared to work for a long time without any feedback, and to do this he needs an experienced clinician as supervisor, whose role it is to encourage and help the therapist to sustain his effort.
2. Every symptom, every verbalisation, and every action of the patient is seen as meaningful, and the meaning as knowable.
3. The consciousness of the schizophrenic is dominated by the unconscious and the patient is terrified of the latter. His defenses are strong but brittle, and collapse under stress. This collapse is often felt as a threat to life, that is, just prior to a psychotic break, the patient feels a threat to his psychotic adjustment and often has an overwhelming fear of death.
4. Resistance in the psychotic patient is qualitatively different from that of a neurotic, and, according to the authors, presents the chief difference between working with these groups of patients. A neurotic resistance is conscious and when a neurotic solution or symptom is challenged, anxiety emerges. The patient can eventually own his problems and work with the therapist in finding alternative solutions. With the psychotic, however, the resistance is both conscious and unconscious and the patient knows he

has symptoms but literally believes he will die without them. The therapeutic work poses a threat of death, and the patient is terrified. The patient is understandably unwilling, and it is only complete desperation, or else an attempt to get the therapist to leave him alone, that motivates any cooperation. However, say Karon & VandenBos (p.144), if the therapist is nonthreatening, does not interfere with the symptoms or interpret, and is willing to wait long enough, the transference needs will emerge and a therapeutic relationship can develop.

5. The authors state that the transference has three main functions. These are: i) providing protection and dependency gratification, ii) to promote insight (as with neurotic patients), and iii) to provide a model for identification for both ego and superego functions, which is necessary because of defective models in the patient's family and the lack of corrective influences from outside the family in the patient's early life.

6. A most frequent error, say Karon & VandenBos, is the therapist's 'refusal to be strong and active when the patient requires and a refusal to relinquish that role when it is no longer required'. If the therapist refuses to let the patient grow up, the trauma of childhood is repeated, and the patient, although having lost his psychotic symptoms 'will always remain a dependent child tied to an infantilising therapist'.

7. It is important never to communicate ambiguously, as this is seen as a threat to the patient. Ambiguity is interpreted as hostility, malevolence and destructiveness by the psychotic patient.

8. The authors say that successful psychotherapy with schizophrenics requires dedication, commitment and a desire to do this type of work. This statement is borne out by Green (1953; Bellak 1958, p.338), who says that the therapist will be puzzled and confused and will resonate the patient's anger, depression and fear, and must be willing to tolerate these.

9. It is important to establish an emotional contact in the first session - to establish the therapist's existence (as a reality and also a transference figure) and his real desire to communicate and help. The therapist's goal is to establish a therapeutic alliance in whatever way possible.

10. Karon & VandenBos (p.139) stress the importance of the therapist's personality in psychotherapy. They say it is important to be human, to be willing to make mistakes, and not to appear omnipotent. Other therapist characteristics found to be essential are 'sincerity, straightforwardness, freedom from anxiety, personal security, and a flexible attitude towards conventions and prejudices',..... '(to be) willing to give of himself and possess infinite tolerance' (Brody; Bellak, 1958, p.339).

11. The authors suggest two principles of interpretation ; the first being to offer 'commonsense rather than psychodynamic interpretations' until such time as the patient wants to go further; the second is to 'never do for the patient what he can do himself', ie., his own insights are far more valuable,

although earlier in psychotherapy the therapist will have to do more.
12. The attitude of the therapist should always be one of giving; he must be perceived as a giver not a taker - a nonpunisher and nonpoisoner, as the typical schizophrenic patient has felt deprived all his life.
13. The therapist can also be helpful with practical issues as his life-experience is probably broader than that of his patient, and offering information etc., can be seen as helpful and benevolent by the patient. The patient will often not be able to use what the therapist gives him, however, and it is important to deal with this noncritically.
14. It is useful to give patients a sense that they experience part of the human condition, as schizophrenics often think of themselves as different from other people.
15. The therapist must make the distinction between thoughts and actions as the patient will often be unclear that they are different.

I will not cover the details on working with delusions and hallucinations except to say that the authors see the structure of hallucinations to be essentially the same as dreams and say that they should be treated as dreams - ie., ask for associations, make sense of them and bring them meaningfully into the context of the patient's problem.

This text and these recommendations were encouraging, exciting in their optimism and, indeed, at times inspired my flagging enthusiasm; but for all the comfort and inspiration it seemed, in fact, that none of what they suggested as helpful in establishing contact, in deepening rapport, in developing the relationship or the therapeutic work made any difference whatsoever.

But let us put treatment recommendations and successful research findings aside for the moment, and remember that even in the light of such favourable commentary on the value of psychotherapy for the treatment of schizophrenia, institutions, as advocates of the medical model hold a highly dissimilar view and, as such, are no meagre force to deal with. Arguments are largely based on costs regarding hospitalization stay, a 'symptom removal' ethic, the view of schizophrenia as 'illness' and so forth. There is ample literature covering this area, and the debate is hot and long, and it is not my intention to cover it here by any means. I will therefore raise only a few relevant issues in the following section.

### 2.4. Philosophy of Institutions - 'Symptom Removal' Ethic, or, the Medication Versus Psychotherapy Issue

Among the writers who enter this debate are those who insist that

medication interferes with psychotherapy, those who see medication as a useful adjunct to psychotherapy and those who feel that psychotherapy is costly, slow and impractical - and for those reasons, even unethical - and thus, that medication is the treatment of choice. I shall limit my discussion to one or two examples of some of the various views, beginning with those which are more psychotherapeutically orientated.

Romanyshyn (Rhodes University Seminars,1990) figures the psychotherapist in four different ways and outlines the implications of each. These are: the psychotherapist as physician, as secular priest, as detective/parent and as witness. In the institutional system one is confronted with the ethic of symptom-removal, where the attitude toward the symptom is negative and it is seen as something to be eliminated as quickly as possible. In this setting, the psychotherapist is forced to figure as physician, and has as his task to take charge of the patient who is 'ill or sick'. The shadow side of this is that the patient then becomes figured as helpless, passive and dependent, and his symptoms are taken away from him. For Romanyshyn, where symptoms are 'the speech of the suffering soul; an index of incompleteness and a call to wholeness, .....an index of a refused destiny, a vocation and also a sacrifice' - to use drugs is 'to silence the soul' and this, he says, amounts to 'an eclipse of what makes the work of psychotherapy psychological'. To attend to symptoms medically is to attend to the 'mind' and perhaps the 'body' but to ignore those dimensions of existence that we call the 'spirit' and the 'soul' -all of which make up the psyche -as part of the full psychological human being. Romanyshyn says that in the modernised, medicalised, and increasingly legalised world of psychology - where the fantasy exists that it is possible to make everything visible, with its corollary that one can always be 'fully accountable', the one place where soul has survived is in the psychotherapy room. To use drug treatment is then, in his words, 'inimical to the soul'. However, Romanyshyn is always aware that there are people without the resources to make soul's journey, and so need medication. In fact, it was his impression (through our discussions in supervision and through listening to audiotapes of some the therapy sessions) that my patient was most probably one of these.

Liberman et al. (Strauss et al.,1980, p.49) say in no uncertain terms that:

'the psychotherapeutic hearth for schizophrenia glows and warms its adherents only in a few academic ivory towers and private psychiatric hospitals, while most of American psychiatry is swept by a tide of psychotherapeutic nihilism.....(and where) the question is not whether intensive.....(or brief).....psychotherapy is of value.....but rather, whether the patient will have time to brush his teeth and take a

shower before being discharged through the hospital's 'revolving door' with fluphenazine in his butt, a prescription in his hand, and an appointment to see a well-meaning but harrassed after-care worker two or three weeks later'.

This, unfortunately, seems to be the presiding attitude of institutions, not only in America but everywhere, and certainly the one with which I had to contend -at least to some degree. While the above writers advocate a psychosocial approach and they agree that medication reduces symptomatology and facilitates interpersonal functioning, it is clearly stated that the treatment of schizophrenia involves more than just that. The argument they put forth is that medication does not decrease readmission rates, it can have devastating and irreversible side-effects, that the non-compliance rate is serious and reduces efficacy, and that the schizophrenic is no better off insofar as learning the social and life skills which are necessary for survival, and for a satisfying community life.

Bruch (Strauss et al., 1980) takes a similar stance and asserts that drugs, while improving dramatic symptoms, do not 'improve or correct underlying symbolic deficits, inadequate life experiences and unrealistic expectations from the therapeutic relationship'. However, she acknowledges that they serve as a useful adjunct to psychotherapy and can, in fact, facilitate the therapeutic relationship.

According to Karon & VandenBos (p.215), who advocate psychotherapy as the treatment of choice, however, psychotherapy is often seen by institutions as 'window dressing', or as an adjunct to medication or ECT, and they warn that these interfere with psychotherapy although the therapist may be expected to work in such a manner.

Carpenter (Strauss et al., 1980, p.295) supports a combined medication/ psychotherapy approach but claims that delaying medical symptom-removal can provide a better basis for a therapeutic relationship, as it can help to create a shared understanding of the rationale for such a decision as well as improving the capacity for introspection, and thus facilitate the exploration of behaviour as communication with a view to the enhancement of ego-functioning. He adds that 'one treatment should not preempt the other' and that 'sequence and context are critical'. As it turned out, this was the prodedure that eventuated with my patient - but I do not want to preempt the treatment discussion at this stage.

Having presented a not-so-brief discussion of some of the relevant literature, or at least the literature which I found inspirational, if not exactly helpful during the process of psychotherapy with a residual

schizophrenic, I will now proceed to a description of the case-study method as a preliminary to the presentation of the patient.

# CHAPTER 3

## 3.0 Case-Study Method

### 3.1 Description and Rationale

Bromley (1986) defines the Psychological Case-Study as: 'a scientific reconstruction and interpretation, based on the best evidence available, of an episode (or set of related episodes) in the life of a person'; in other words, a case-study is an 'account of how and why a person behaved as he or she did in a given situation'. The value of a case-study is two-fold, firstly, where it makes a particular case explicable, and secondly, where it contributes to the 'case-law' of that particular area of discovery. Case-law or (theory) is developed by successively comparing and contrasting intensively studied individual cases. In this way, knowledge is gradually systematised and refined and subsequently 'rules, generalisations and categories' emerge (Bromley,1986, p.2).

There are various types of case-study whose aims embrace a broad range of tasks. Edwards (1990) outlines and places some of these on a continuum from simple description, through theory development to critical theory-testing (Mohanty; Giorgi,1986; cited in Edwards, 1990).

The case to be presented below fits into a further category known as Illustrative-didactic. It is different from those on the above continuum in that it is neither merely descriptive nor does it presume to contribute towards the process of theory construction or theory testing. The Illustrative-didactic case-study method adopts the use of illustrative material from the case (from 'short vignettes' to 'fairly extended and complex case descriptions') as a central feature in 'the development and communication of theoretical conceptualisation', and in so doing, provides 'evidence for the generality and validity of case law' (Edwards,1990. p.22). Edwards (1990, p.35) writes that the didactic role of a case-study is the 'elegant demonstration(s) of theoretical principles' and further, that it offers an important contribution to 'the body of case-study research literature'. This type of case-study thus fulfills both of the functions described by Bromley above.

While it is possible that the description 'Illustrative-didactic' does not quite cover the type of research method I have used to document my project, I have not been able to fit it better into any other category. It cannot justifiably be described as a Theoretical-heuristic study, since while it is true that existing theory on psychotherapy for schizophrenia

did not satisfactorily address my problem, neither is what I have finally conjectured particularly rigorous or formalised (theoretically) - in the sense that it may expand existing theory. Similarly, while to describe it as a Descriptive-dialogic case-study covers the focus on description, and explains where my study 'provide(s) an informal test of the content of specific theories, or test(s) whether the conceptualisation is adequately differentiated' (Edwards, 1990, p.19), somehow this term fails to reveal the illustrative nature of my case-study, and neither have I attempted to be sufficiently rigorous, or to operationalise events with particular regard to the process of theory construction as this methodology necessitates. The Exploratory-descriptive study has as its aim to reveal in depth, and provide an understanding of a particular case, but without any 'urgency to generalise to other cases' (Edwards, 1990. p.18). This too was my design in writing up this particular case, but I have paid considerably more attention to existing theoretical conceptualisations than this category of case-study generally requires.

It thus seems that some or other aspect or aim of each of the categories is pertinent to my work, and since these categories are not exclusive and exist on a continuum, it is difficult to slot it with any exactitude into any one category. The term Illustrative-didactic seems to offer an acceptable solution.

### 3.2 The Question of Validity in the Case-Study Method

Validity in the case-study method is not achieved through statistical inference (as in the experimental method), but by a process termed 'analytic generalisation by Yin(1964) or analytical induction by Mitchell(1983)' and where the more important concern is 'the validity of the analysis rather than the representativeness of the events' (cited in Edwards,1990, p.13).
Edwards (1990, p.27) states that the case-study method has an important advantage over the experimental method in that internal and external validity are not generally achieved simultaneously in experimental research and, in fact, usually each is obtained at the expense of the other, whereas in case-study research this is avoided; external validity is maintained through adherance to the detailed examination of 'persons or events in, or as close as possible to their natural contexts' (Yin 1984; Edwards,1990), and internal validity is maintained through the use of logical inference.

Bromley (1986, p.15) states that 'results from a case-study are by definition valid and reliable, and capable of being replicated or otherwise confirmed', and that the idea that a case-study can only be exploratory, and that an

experimental study is infallible, is erroneous. He continues to say that 'all scientific methods of inquiry can be exploratory and none can be definitive in the sense of giving results which are incorrigible ie., beyond refutation or correction'.

While it is true that there is a subjective element in data collection for the case-study method, and that investigator bias needs to be considered, it is also true that the psychotherapist, within the arena of the therapeutic relationship, has priviledged access to unique and invaluable aspects of qualitative data, which would be unobtainable other than within the context of a trusting therapeutic relationship which develops over time. In this way, the practitioner-as-scientist can obtain an 'insider's' view, which, with attention to his own processes in the relationship and his clinical skills in 'listening, empathic responding and searching questioning' (which are essentially research skills also (Edwards,1990, p.8)), can provide the 'insiders' in the study with an 'outsiders', or objective view of the case (Bromley, 1986, p.15).

My aim in having chosen to write up this particular case is similar to the rationale used in the writing up of a quasi-judicial case-study.
According to Bromley (1986, p.37), this is 'to formulate a cogent argument ie., a rational and empirical argument (a theory or explanation) which addresses the behaviour of the person under investigation'. Through the making of what Bromley (1986, p.38) calls a 'complex web of evidence and inference' which I will begin to do presently, I hope to increase my personal understanding of an experience of psychotherapy with a residual schizophrenic, and also to contribute, at the very least, something of interest to the body of psychotherapeutic case-study literature. It is my intention to make, if not a 'correct' or 'true' interpretation, then at least the best possible interpretation of my patient's life, his psychic world, and most importantly, of our work together in psychotherapy.

Whether or not I succeed in finding the missing pieces of the puzzle which became a metaphor for my patient's life will perhaps be better answered by the reader rather than myself.

### 3.3 Data Collection and Procedures

The patient is a 24 year old, single, white male in the residual phase of schizophrenia, who was hospitalised for inpatient care for a period of approximately five months. In order to protect my patient, his name and various details of his life history have been changed, disguised, omitted or

added.

During this time I saw him for psychotherapy three times a week initially. Later the sessions were reduced to twice and finally once a week. Psychotherapy sessions took place in my office on the admissions ward of a psychiatric hospital for a total of 42 sessions during a four and a half month period. The sessions were generally of 50 minutes duration but on occasion would extend to 90 minutes.

Psychotherapy sessions were carefully documented from memory directly after each session - as close to verbatim transcripts as possible were attempted. There were also approximately 15 hours of audiotaped sessions available for transcription. In addition, I saw the patient in an inpatient group-psychotherapy setting for one hour, twice weekly. After three months another intern psychologist took over the group-psychotherapy sessions and she would report to me on his participation from time to time.

Apart from an initial psychiatric and history-taking interview and personality testing (done in my capacity as an intern in the hospital and as part of a routine intake procedure), a file from a previous (his first) hospitalization was made available, in which was a fairly detailed account of his psychotic episode, and also many details of his early childhood and developmental history in a letter which was written by his mother.

All psychotherapy sessions were carefully supervised by a practising clinician through the use of written transcripts, audiotapes and the detailed notes made from memory. Audiotaping of sessions was introduced primarily as it was felt that the quality of the therapeutic relationship and of the patient's psychic experience, and also that of the psychotherapy sessions in general, might be appreciated more fully by the supervisor. The case was presented to a visiting lecturer (R.D. Romanyshyn,1990) for further supervision before I began the project.

# CHAPTER 4

## 4.0 Introducing the Patient

## 4.1 Identifying Data

The patient is a 24 year-old, single, white, male who will be named **Jesse Harper** for the purposes of this project.

## 4.2 Reason for Referral and Referral Source

Jesse has had two psychotic episodes. The first (a brief and not seriously debilitating episode) occurred in November of 1988, the second, which occurred in August, 1989 was more serious and resulted in a two-month hospitalisation (see section 4.3 below).
Jesse was admitted to Fort England Hospital in January of 1990.
The admitting doctor requested an assessment for psychotherapy as the patient was 'extremely amotivated, had severe feelings of insecurity, was afraid to mix with others and scared to leave the hospital'.

## 4.3 Presenting Problem

Jesse said he came into hospital because he *'was ending off his medication'*, that he *'didn't fit in at home - as he was not getting on with his mother, could not entertain himself, had no interest in hobbies and felt at a dead end'*.
He described having felt *'a nervous tenderness'* for about a month prior to what he termed his first 'breakdown'. He spoke of that episode as an *'identity crisis'* where he *'lost touch with who he was, lost his bearings, his point of reference'*, and went down to the river where he found he felt better after about 2-3 hours. He said that during that time he lost contact with his 'self', his 'I' or 'ego', and felt that he was going insane. He thought that it was *'nervous exhaustion'* and that he needed to rest. He did not work for about a month during which time his identity became stronger. Shortly after that episode he left his place of employment and embarked on a course of study in agriculture which he felt was the ideal occupation for him, but he said that even in that environment he had an *'identity crisis'*.

The second episode, some eight months later, began with what Jesse described as 'a two day build-up' where he lost contact with people and did not know anymore if he was dreaming or waking. He went up the mountain for a two-day hike and 'to clear his head,' but found that he lost all contact

with reality there, and thought that if he got in touch with people he would feel better. He came down from the mountain and sat by the roadside - but as a big truck came past, he threw himself under it. He said he did not think anything at all, just did it. He was admitted to a general hospital with a broken pelvis and legs and was transferred from there to a psychiatric hospital after 10 days. There they found him to be acutely psychotic, and he was heavily medicated and remained for 2 months before being sent home and referred as an out-patient to the psychiatric hospital in his home town. The side-effects from the medication were severe, and he continued as an out-patient (and was living at home) for two months during which time his medication was gradually withdrawn. During those two months he was continually at odds with his mother over religious matters and a final blow-up occurred at Christmas. It was shortly after that when he was admitted as described above.

### 4.4 Family Background and Highlights of History

Jesse is the second of six children, (the first male child) and was born into a family which is known as somewhat 'odd' or 'eccentric' locally. Jesse has an older sister, three younger sisters and a younger brother. The family travelled around quite a lot, and his early years were spent mostly in farming or similar communities. He was a very much wanted child, and his mother reports that he is the only child whose moment of conception she knows. Apparently there were difficulties with him right from birth as regards feeding, sleeping and excessive crying. These will be discussed further in section 4.6 below.

Jesse reported that as a child he was 'switched off' to the world and to people, and that as far as he was concerned it would not have made any difference to him if his family was there or not. He said he was accused of having no consideration for others, and reports that this was because at the age of 5 or 6 he did not respond to his sister who was drowning in a shallow pool, or to his brother who was drowning in the bath. He said he was very young and did not know that they were in trouble, and also that he does not remember these incidents.

Jesse said that he never got angry as a child just *'deeply depressed and frustrated'* and would break his toys (age ±5 years), but that people would laugh at him so he stopped doing that.
He described having been sent to an uncle and aunt for around one or two months every time a new baby was born, because his mother was afraid he would harm the baby. He enjoyed these times away, as he saw them as a holiday. At around the age of 10 years his mother would often 'send him

packing' when she could not handle him. He would leave home and hitch-hike and be picked up by various people and taken to the police from where he would be sent home. He was not worried about this, just felt he was obeying orders.

I was struck, during the telling of these incidents, by what appeared to be serious maternal/emotional deprivation - and also at Jesse's apparent lack of concern in the present, while relating these events to me, and also in the past over these events; and by the fact that the lack of primary bonding between Jesse and his mother seemed quite severe.

**Relationship with Mother** : Jesse said he was told that he rejected his mother when he was an infant and 'screamed a lot', and that this is something that she always brings up - as she does with many aspects of the past. He described her as very emotional and highly critical, and said that she has very strong ideas (including religious beliefs), and that her word is law. He said he 'likes her a lot', but that when he stands up for himself she does not like it and takes offense, and it is chiefly for this reason that they do not 'get on'. She is committed to her home and family and religious beliefs. Jesse said his mother had a 'nervous breakdown' at some stage but that he did not notice. He could not be more specific than to say that *'she lost her ability to function'* and *'had to learn to do chores again.'* She believes that she was saved by being reborn and that Jesse must do the same.

**Relationship with Father** : Jesse gets on well with his father as they *'think similarly'* and they *'do things around the house and work together'.* He said he felt close to both his parents but found his father more understanding. He said that his illness hurts his father very much, but that his mother is very positive and optimistic and hopeful that he will get better (provided he restores his faith, it seems). Jesse said he cared about his parents *'but it's not an emotional set-up.'*

**Education - Schooling** : School seems to have been mostly uneventful and Jesse passed Matric with a 'C' aggregate. He said that he could have come top of the class, but did no work at all as he was not really interested in school subjects. He left school during Std. 9 (as he could not see the point) and went to work with his father, but after listening to an inspiring lecture on the value of education, he decided to return and completed Std. 9 the following year.

**Psychosexual Development** : Jesse said he had a girlfriend once for 4 or 5 months *'because everyone else did'*, but when she found someone else he

did not mind because he *'didn't see the point anyway.'* The relationship was not sexual, nor has he had any sexual relationships, nor any girlfriend since then. Jesse told me that he had made a decision at some point not to have sex with anyone until he was married. I do not have any information on sexuality or sexual issues eg., sexual fantasies, sexual feelings or masturbation.

**4.5 Basic Personality** : Jesse described himself as *'the sort of person who did not flirt with things but liked to dive in at the deep end'*, but he said that now he was hesitant to do this, that he did not have the confidence - especially as regards going back to work. Jesse described himself as *'a cool-headed person'* to whom it made no difference whether he was alone or with people, since he *'lives in his own world'*. He said it did not matter to him what other people thought of him at all. He said he never became angry since he could not see the point.
There is no history of alchohol or drug use.

**Interpersonal Relationships** : Jesse said that did not try to get along with people, just tried to be acceptable, to neither ask nor offer anything. He felt he had nothing to offer in relationships and he was secure and less vulnerable with this way of being. He said he was not a 'small talker' and did not make any effort to join in with people. He preferred to keep out of the way. Jesse has had only one friend since the age of 12 when he left the farm school. About this relationship he said, *'we never used to talk, we would just build trains together'*. They lost contact when his friend was married.
Jesse said he could not be involved in relationships now because of his illness - as he was unable to handle any responsibility - he had to be independent so that he *'could die and not affect anyone'*.

### 4.6 Premorbid Functioning with Focus on Childhood

The question of Jesse's premorbid functioning is important, and one which must be raised, since while a dynamic understanding shows a person who is anæsthetised from his feeling life, and many hypotheses can be made regarding this, it is also possible that his life was never one filled with much vitality. However, the degree of his suffering in his present condition became clear when he said *'that he knew he was lost, and hoped he would get back to what he was'* - that *'he felt blank and distant and kept himself out of the way so he could exist without putting on masks or faces - just be himself and nothing more'*.

In order to address the question of his premorbid functioning, I propose a

description of Jesse's childhood development which diagnostically appears to fulfil the DSM 111-R, Axis 11 category of Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS). The information for this section was made available in a letter written by his mother which was in his previous hospital file.

### 4.6.1 Pervasive Developmental Disorder NOS (PDDNOS).

This diagnosis is given where there is qualitative impairment in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. PDDNOS is described as a general category where the most severe and prototypical form is the Autistic Disorder. The manifestations of the disorder (PDDNOS) are described as lifelong, although they vary with age and in severity. Long-term prognosis is relative to IQ and the development of social and language skills. The DSM III-R states that in very rare cases the individual may complete college, or even university education.

Adults with this disorder may have many of the 'negative symptoms' of the residual phase of Schizophrenia, such as social isolation and withdrawal, markedly peculiar behaviour, blunted or inappropriate affect and oddities of language. However, a marked lack of motivation, interest or energy is not included with these symptoms, and Jesse clearly reported that his functioning in that respect was not at its premorbid level.

The DSM III-R asserts that in response to stress a catatonic excitement or posturing, or an undifferentiated psychotic state with apparent delusions and hallucinations can occur, but these clear quickly if the stress is removed. However, at the time of his second hospital admission, the residual symptoms of Jesse's psychosis were clearly still in evidence.

Although the diagnosis of Schizophrenia takes priority over the diagnosis of PDDNOS, and clearly is appropriately given in this case, from the report on his childhood written by his mother, it seems that Jesse could be given the diagnosis of PDDNOS as a description of premorbid functioning on strength of the following criteria:

**4.6.1.1 Qualitative Impairment in the Development of Reciprocal Social Interaction:** Jesse's mother reported a marked lack of awareness of the existence of feelings in others, said that he would never notice another person's distress or need, and demonstrated a lack of imitative behaviour. She describes having to teach him how to hold hands with her (by curling his fingers around hers and giving a squeeze), and to

kiss her hello and goodbye.

**4.6.1.2 Impairment in Communication and Imaginative Activity** -this includes both verbal and nonverbal skills. Jesse's mother reported a lack of attachment to objects and people, as well as abnormal social play, eg., he would not participate in games, preferred solitary activity, and failed to develop cooperative or imaginative play and friendships - even with his siblings and despite all her efforts to encourage him. She said he would sit under a table and do nothing, he would never invent games. It appears that Jesse found adults interchangeable and he said that he was equally free and happy with everyone, and his mother reported an incident where at the age of five, after a house visit to a relative stranger, he wanted to stay and live with her - and had to be dragged to the car kicking and screaming when it was time to leave.

She reported that at about three years, she felt his language was 'all wrong' or, in fact, nonexistent. She said he would hear and be able repeat word for word what she said, but he would have no picture in his mind of what she had communicated to him, and that acting-out or miming what she wanted him to do made communication with him much more satisfactory. She complained of his monotonous tone of voice, lack of facial expression and innapropriateness within the family. She said that he was never part of the family. However, she invited him to join the family at the age of seven, at which time she outlined what was required of him and he responded positively.

**4.6.1.3 Markedly Restricted Repertoire of Activities and Interests:** Jesse's mother reported that he hated to move his body and she gave various examples of this. She said that he loved to build things, but would never play with them once the creation was completed.
There also seem to have been some abnormalities in sleeping (eg., not sleeping through the night for a protracted period and of sleepwalking - but this was after a bedwetting episode and was limited to sleepwalking to the toilet. There were also instances of idiosyncratic eating. His mother described more than one episode of his wanting to eat only one item and where he would do so until the stomache pain was intolerable. She said that he could not connect the pain to the eating and would just carry on eating and crying. His mother wrote that he would not accept anything or any authority from her, nor any of her explanations and often needed to be told that certain things, eg., going to school, were demands which were not of her making in order for him to comply.
I have chosen only a few of her numerous examples.

## 4.7 Psychiatric Examination (Mental State)

### 4.7.1 General Appearance, Behaviour and Speech

**Appearance** : Jesse is of average height and build, is slim and fairly strong-looking, and was clean and neatly dressed. There was nothing particularly untoward about his appearance. It was the height of summer and he went about barefooted, bearded and with his dark hair unkempt. He appeared to shuffle along, slightly bent and a little wearily.
**Behaviour** : Jesse was pleasant and compliant, but somewhat passive and distant in the initial interview, and it did not seem to matter to him one way or another what we did or spoke about. Although he seemed fairly relaxed and did make eye contact with me, and was serious and attentive at all times, his facial expression appeared restricted, and I somehow got the feeling that he was not very present in the interviews. He understood my questions and followed my instructions perfectly.
**Speech** : Jesse spoke readily and at length about his illness. His speech was fluent, coherent and logical but his tone was monotonous and seemed consistent with an emotional flatness.

### 4.7.2 Affect and Mood

**Affect** : Jesse described having been emotionally flat for so long that he could not remember what he was really like. Although he had a relatively pleasant expression most of the time, he did not seem to reciprocate any smile or gesture of mine but simply to obey and do what he was told. He did, however, seem quite pleased with some of his productions - eg., while doing the TAT and Rorschach he smiled and laughed quite spontaneously. He shed a few tears when he spoke of his father's reaction to his illness. However, although he seems genuinely concerned with the implications of his illness for his work, he appears emotionally detached from the meaning of it otherwise. I did not notice any anxiety through the interview or the testing, but Jesse said he felt very worried about a relapse because he '*got run over last time*.' He also feared losing his faculties, or his senses, his intuitiveness and his ability to understand things.
**Mood** : Jesse appeared blunted and somewhat slowed. He denied being depressed, but said that he had been severely depressed during his previous hospitalization - to the extent that he '*wanted to stop living*', '*to vanish*', but he said that he did not have the guts to kill himself.
There was no evidence of manic or hypomanic episodes in his history, beyond restlessness and inability to concentrate, especially while he was heavily medicated.

**Suicidal Ideation** : Jesse reported often having had suicidal thoughts and longing not to exist -especially during his previous hospitalization where he gave up hope as the medication made him feel really bad, but he said that he could not think of a peaceful way to kill himself. He was not suicidal at the time of the intake interview. Jesse said that he had often thought about hurting himself, eg., bashing his head against the wall, but always felt it would be futile. Throwing himself under a truck was not a conscious suicide attempt.

### 4.7.3 Thinking

**Organisation of Thought**

**Flow and Form** : There appeared to be no abnormality in Jesse's flow or form of thought, although on examination of the TAT stories his thinking was very slightly less logical than it appeared when conversing with him. There were times when he could not exactly correlate dates pertaining to his illness, but these observations did not seem to be particularly significant.

**Possession of Thought** : Jesse was clearly in full possession of his thoughts at all times during his contact with me. However, during both psychotic episodes he reported that he had had no control over his thoughts - *'it was as though they were turning inside out and thinking themselves'.*

**Content of Thought**

**Delusions** : Jesse clearly described delusional thinking prior to, and during his psychotic episodes. He experienced delusions of reference in which he thought his presence affected other people - for example, *'someone would turn his head because he was annoyed with me'.*

Other than ideas of reference, he described telepathy (eg., where he thought he had sorted out his religious differences with his family), and vivid, realistic dreams - to the extent that he did not know the difference between his dreaming and waking. He said he thought that these abilities were very special. He said that he would lose contact with people where he would hear them talking but could not interpret the meaning of the words. Jesse said he realised all this was 'his imagination' when he found out he was in a mental hospital (six months previously) and was told that he had schizophrenia. There was no delusional thinking during the time of my contact with him.

### 4.7.4 Perception

**Distortions** : Although there was no evidence of perceptual distortion during the time of the intake interview, there are clear instances of

depersonalisation and derealisation during his psychosis. Jesse said that before his major breakdown he felt as though there was evil all around, and said that he had attributed evil to the smell of sulphur from a local chemical factory. He said that his experience at that time was of being in a horror movie - '*when things happen and you cannot change them*'. He said that he was not frightened but just observing, '*as though it was somebody else participating*'.

**Deceptions** : Jesse described having experienced the influence of supernatural forces. He said it was '*a force or a spirit or a ghost*' which had caused him to land up under the truck by '*pushing him from behind his head*'.

**Hallucinations** : Jesse did not describe any hallucinations during the assessment interview, but his previous hospital file reported the following:-

Auditory hallucinations - sounds which fit with 'Egyptian evil' and voices that talk back to him;

Olfactory hallucinations - the smell of a woman's uterus;

Tactile hallucinations - the feeling that a snake-dog-cat was biting his legs.

### 4.7.5 Cognitive Functions

**Awareness** : Although I did not administer any cognitive tests, Jesse's attention and concentration levels appeared normal. There appeared to be no abnormalities in his levels of awareness or arousal either.

However, Jesse's awareness was clearly impaired during his psychotic episodes and he said that he had repeatedly taken cold showers while in hospital (1-1/2 hours on one occasion) to '*wake up his consciousness*,' or to '*clear his head*'.

**Orientation**: Jesse was fully oriented for time, place, and identity at all times during my contact with him. I have no information on his orientation during the active phase of his psychosis.

However, he said that his identity had changed over the last 6 months, he had stopped thinking to himself and that there was nothing to him, that he had no ego, no soul- and that he was just existing.

**Memory:** Jesse said that during his psychotic breakdowns his memory had been 'weak' but as he got better, it became 'stronger'. Although I did no formal memory testing, his immediate, intermediate and long-term memory functions appeared intact on an everyday level.

**Intelligence** : Jesse is clearly highly intelligent and showed a good capacity for abstraction.

**Insight**: Jesse showed clear insight into his deterioration and illness, and was fully aware of the implications or effect on his social, emotional and

occupational functioning. Jesse's arguments against taking medication showed really remarkable intelligence and insight (see my comments in section 4.10 below).

**Judgement** : Jesse's capacity for judgement seemed intact. He was realistic about the future and the implications of his illness in terms of his ability to handle responsibility and stress, and to manage his own affairs.

**Motivation** : Jesse said he had felt totally demotivated for the past 6 months - it was difficult to set a goal and he felt he was not ready to tackle anything. He was very concerned about his lack of motivation and energy and his inability to change these, and the implications of both these (in a practical sense) for his future. Jesse said he could not think things through, he made mistakes and he struggled with work and passing the time. Jesse said he often felt bored (especially at home) but that he felt safe at the hospital because he could just do his jigsaw puzzles. It bothered him that he was happy and content at the hospital, as he felt he should be out working and that he had 'rested long enough' - but he said he did not have the motivation. He described 'doing things' as 'beginning all the time' or as 'working backwards'. He seemed to struggle with the conflict between keeping busy or working, and needing to rest.

## 4.8 Diagnosis

For the purposes of this project, schizophrenia will be defined in accordance with the medical model as proposed by the DSM 111-R. The criteria are outlined under the subheading 'Discussion' below.

**Axis 1 : Schizophrenia - Undifferentiated Type**
**Residual Phase - Subchronic**
**Axis 11 : Pervasive Developmental Disorder NOS (Premorbid)**

**Discussion**

**AXIS I: SCHIZOPHRENIA**

Although Jesse was not actively psychotic at any time during my contact with him, from his previous hospital file, in which there is a report on the active phase of his psychosis, there clearly exist criteria for the diagnosis of schizophrenia to be given. The following are noted:

**A:** (a)**delusions** (telepathy, special abilities, ideas of reference and experience of supernatural forces)
(b)**hallucinations** (auditory, olfactory and tactile)
(c) flat **affect**
**B:** Deterioration in social and occupational functioning.

**C**: Schizoaffective and Mood disorder with psychotic features have been ruled out.
**D**: There exist continuous signs of the disturbance for at least six months.
**E**: It cannot be established that an organic factor initiated and maintained the disturbance.
**F**: If there is a history of Autistic disorder, the additional diagnosis of schizophrenia is made only if prominent hallucinations or delusions are also present.

The type is classified as **UNDIFFERENTIATED** on the grounds that it does not fit the criteria for Paranoid, Catatonic or Disorganised type.

**RESIDUAL PHASE** is classified where there is persistence of at least two of the symptoms from a specified list (p.194). The following apply:
1. Marked social isolation or withdrawal.
2. Marked impairment in role functioning as wage-earner.
5. Blunted affect.
9. Marked lack of initiative, interests or energy.

The term **SUBCHRONIC** reflects that the prodromal, active and residual phases inclusive, are of at least six months but less than two years duration.

For the sake of brevity I will not discuss any differential questions beyond saying that I considered an Axis-II diagnosis of Schizoid Personality Disorder as a premorbid description, but this usually emerges in early adulthood, and Jesse has manifested developmental symptoms as from earliest infancy. An Autistic Disorder was considered, but the developmental issues as described by his mother seemed less severe than what is required for the diagnosis of Autistic Disorder to be made.

### 4.9 Dynamic Formulation

Although Jesse reported that things were 'fine' for him as a child, it seems that he was mostly oblivious to what was going on in the world around him. He said he never noticed his lack of awareness and was unperturbed by his unrelatedness and lack of attachments - he said *'things were only wrong for other people'* - mostly insofar as he did not fit in with the family. It appears, however, that since he was born he has lived in a world which experienced him as rejecting and which, in turn, rejected him- and where his very existence was an offense to those around him, most specifically to his mother. There are many examples in his family history of her difficulties with him and her response to these.

It seems that Jesse has always lived in his own, somewhat autistic world- but whether this was by nature, or as a response to an unsatisfactory environment or as a result of some combination of the two, is uncertain. However, from his mother's account of his infancy and childhood there clearly are factors from as early as the time of birth (eg., being born with the cord around his neck and a refusal to breastfeed), which are indicative of natural factors contributing to the untenable relationship between them.

Jesse reported that his greatest fear was of offending people and it seems that his way of relating to others is a manifestation of this fear - the less he interacts closely, the less chance of offending anyone. According to Langs (1981), in writing about schizophrenia, every symptom has a specific and unique meaning for the individual - one whose underlay is repressed rage and hostility, but which is also a way of making survival possible. Jesse's social withdrawal, which is also a rejection of his environment, could thus be seen as a way of communicating the anger and rage he feels towards having been rejected, and also his fear of the anger. Karon & VandenBos (1981) state that human beings are unable to extrapolate and repress any <u>one</u> feeling, and thus, in attempting to repress anger he has, as a result, also lost his vitality and motivation. His emotional flatness could then be understood as a defense against anger, as a response to a world in which it is not safe to want or to need - and most certainly not to express those needs or make demands, or in any way to trust or even hope that any needs will be met - it is a world where his demands are, and always have been experienced by his primary caregivers as overwhelming.

Jesse's psychosis can then perhaps be understood as the ultimate defence, (or his mother's ultimate triumph) - where he had to go 'crazy' so as to end, or to escape the 'clash of wills' between them. However, the psyche has the ability to judge the extent to which it has to act in order to defend itself, or to survive, or to create the space for its transformation. It appears that while Jesse did <u>not</u> have to stay overtly psychotic, he <u>did</u> have to stay non-functional in the world, and especially within the family, for the drama between him and his mother not to be reinstated. He has achieved this by retaining the residual symptoms of schizophrenia - that is to say, they are his defense against insanity. One can only respect and trust the healthy part of the psyche, which, as Perry (1980), says 'know(s) what it is doing and how to do it'.

## 4.10 Rationale for Psychotherapy with This Patient

At this point the reader may question why, in the light of the institutional attitude towards psychotherapy as treatment for schizophrenia, with my cognizance of the patient's schizoid or autistic type of premorbid functioning, my relative inexperience, and my lack of experience with schizophrenia in particular, did I undertake psychotherapy with this particular patient?

Well, apart from perhaps some unconscious or naîve fantasy of success, or a kind of grandiosity or possible omnipotence - of which I was not aware at the time and only able to consider in retrospect (see 6.6), there was something very appealing about the patient himself. But more appealing still were the anti-medication arguments with which he approached me subsequent to the initial history-taking interview. These remarkable and extremely insightful concerns will be detailed below.

In response to the suggestion of medication by the hospital doctor, Jesse was put in a state of turmoil and came of his own accord to my office, where we had an inpromptu session which lasted 1-1/2 hours. Jesse was clearly deeply concerned at the idea of taking medication, and voiced his fears and reservations as follows:
Firstly, his difficulty with taking medication was not just an 'anti-medication principle' or any belief of his own, nor was it based entirely on his previous, and clearly frightening experience with medication, nor was it in accordance with the wishes of his family. Secondly, Jesse felt that if he took drugs he would never know if he could have 'got better' on his own, and this would be like admitting failure before he knew he had lost. Thirdly, he said he almost wished he would have a relapse so that he would know for sure that he could not cope - it would give him some way of knowing that he was ill, and really needed medication. He said he would take it then. Fourthly, he felt that his sense of identity was tenuous already, and taking drugs would make that worse. He felt that the medication would change him- and that was frightening, as he had already changed to the extent that he did not really remember or know who he was. He felt that it was really important for him at that point to know what was '*the best that he could be*'. Fifthly, Jesse felt that taking medication would remove the final vestige of control that he had over his life, his thoughts, his feelings and behaviour as his previous experience with anti-psychotic medication had shown. Sixthly, he felt it would interfere with the little independence, autonomy and freedom he had, since he would become dependent on chemicals to live his life. Seventhly, Jesse said that taking medication would make him

even more defenseless than he already felt. Eighthly, he said he felt threatened by the proposal, in the sense that it carried a communication that he had overstayed his welcome at the hospital and that he had to 'get better and leave' - but he was not able to do so at that time. Thus, although he had seen the hospital as a refuge up until that point, he felt that he had to run away from the hospital as he had run away from home when he did not fit in there.

The reader can hardly miss the clarity of thought, intelligence, foresight, integrity and appropriateness of his comments and hopefully can appreciate how, on the basis of these extremely insightful remarks, and clearly articulated and, to me, not unrealistic fears, I told him that I would be willing to support him fully, for as long as possible in his decision to try to stay off medication. In support of this then, and so as to appease some of the hospital staff's anxiety about 'doing something' for the patient, and most probably for some of my own reasons as well, I suggested that we work together 3 times per week in psychotherapy, where we could try and find a way for him to gather some strengths and resources, and hopefully make some sense of the world and his feelings - so that he could live in a way that was more comfortable for him.

Jesse responded with relief and even enthusiasm to my suggestion, and I reported back to the medical staff on the basis of the intake interview. I presented his history and my personality assessment, and attempted to represent his concerns with taking medication as well as I could. I also proposed the following motivation in favour of psychotherapy :
1. Jesse is young, highly intelligent and extraordinarily insightful as regards his interactions with others, his defensive manoeuvres, and the relationship between his current problems and his past and family relationships.
2. Since his defenses seem intact, I do not feel that psychotherapy would precipitate any further breakdown, and even if this did happen, he is in a safe place which can hold and contain him.

However, I was not entirely unaware of the possible difficulties for psychotherapy and stated them as follows :
1. It is my opinion that his extreme lack of motivation could interfere with progress in psychotherapy at present.
2. His highly defended manner of relating would most probably make access to him and a therapeutic relationship difficult - at least initially.
3. However, Jesse seems to be 'loosening up' slightly in the ward group-therapy sessions and participating more. I take this as a sign of his potential to change.

4. I feel that in the light of his premorbid picture, psychotherapy goals will probably have to be somewhat limited.

My supervisor was extremely supportive of the idea of psychotherapy, and helped negotiate this management decision during a case conference at the hospital. Without his full and unfailing support for initiating psychotherapy, his monthly motivation at case conferences for its continuance, and also my weekly supervision sessions and the support I felt from him, I very much doubt that I would have been granted the opportunity to try psychotherapy at all, or been able to sustain the effort for as long as I eventually did.

On the basis of our motivation, it was agreed (with reservations) that I could give psychotherapy a trial for one month, after which time the situation would be reviewed.

And thus, psychotherapy began.

# CHAPTER 5

## 5.0 Outline of the Psychotherapy

Psychotherapy extended over 42 sessions and 4-1/2 months. In this section I will outline the psychotherapy as succinctly as possible. I will elaborate further on various aspects of the sessions, draw thematic material, discuss the images and a dream in detail, and provide extracts of transcripts in the Discussion (section 6.0) which follows.

The first session (as described above) was an inpromptu session, in which we discussed at length the option of his taking medication. He appeared to be less emotionally blunted than when I had first interviewed him. He shed a few tears for his father's hurt regarding his illness- he articulated a need for someone to 'reflect his thoughts'- he spoke openly about his insecurity and his difficulties in making and keeping friends, and he beamed when I acknowledged his understanding and his fears regarding the issue of his medication and offered my support in his decision against medication. He responded enthusiastically to my offer of psychotherapy.

In the second session he began to talk about his difficulties with his mother but as I began to empathize with these, he appeared to back off by saying 'things were not really so bad there', and in fact it was when he first left home 5 years previously that he began to fall apart - mostly in the sense that he felt socially isolated and unmotivated to achieve at work. He appeared withdrawn and reluctant to engage in the session. As he left I attempted to arrange his weekly appointment times, but he would not take the piece of paper I offered him.

Jesse did not arrive for the following session (3rd), so I went to collect him from the day-room. This was a pattern which appeared to establish itself - he would arrive for one session, on time, and I would have to collect him for the next. He spoke of just existing - doing the bare minimum- of having cut out all the extras, all the frills, as regards every aspect of his existence - eating, washing, interacting and doing things. He spoke of anxiety about the unknown, of a sense of no future ahead - but at the same time of having a sense of peace in not having to make an effort to change anything. I addressed the idea of psychotherapy in this context and he acknowledged the effort it took. He said that it appeared pointless to just keep telling me how he was feeling, but that without psychotherapy he would give up hope altogether. After this session I overheard him chatting in the passage for about ten minutes to one of the other patients for the first time.

By the fourth session I was becoming aware that the relationship was difficult and uncomfortable for both of us, and I felt called to address the silences and explore his experience in psychotherapy. While doing this I said, at some point, that I wanted to engage with and learn more about him, but that I was not always sure how, or if he wanted me to - only to receive a broad smile and the response: 'well, that's your problem, isn't it?' which I took as an index of his perception of the issue of responsibility in our relationship, his extreme objectivity which I now experienced for the first time, as well as the fact that he still had a sense of humour. Outwardly he appeared to have withdrawn more and had given up doing crossword puzzles (his only occupation during the past few weeks). I was beginning to feel a little desperate, and becoming aware of what seemed like an inability for Jesse to become involved in psychotherapy in a way that was meaningful for him. I suggested, on the recommendation of Karon & VandenBos (1981), that we look at his history by beginning with some early memories. He recounted some brief, but rich memories and laughed heartily at some of his childhood escapades, but they were never without pain, always ending in a stomachache, something broken or not working, his feet being burned by fire or frost, crying over a cricket he had killed and cut up when he wanted to be a hunter etc. However, he did not seem to experience any emotion or to be affectively involved when relating these incidents. He described his as a normal childhood, saying only that he 'was more objective than most people', and that he 'was an unusual person'.

Jesse did not arrive for the fifth session so I went to collect him. He reported that he had nothing to say. He acknowledged that it would be easier if I asked questions and he could then give me the information that I required. I interpreted his anxiety in just being with me rather than giving information, after which it appeared that the session deepened and he seemed to be making an effort to participate. He volunteered more feeling material and I became aware of a willingness to trust opening up. He spoke about making mistakes, about people being an unknown - about things becoming too complex for him where people were involved, and about feeling awkward all the time, except for when he is eating, or taking a walk. This was a very intense and felt like a very long session.

The following session (6th) was a two hour session which he began in quite a defended manner, but after a while he really seemed to reach some of his despair. He spoke about being unable to accept that he was mentally ill, and of feeling 'alright' but realising that he could nevertheless not simply get on with his life. He became quite tearful in the session and actually began crying at one point when he spoke of the hopelessness he

felt. Jesse told me that I was the only person he was in contact with and that I get him to think and that things are being stirred up. He said talking makes no difference, but went on to speak of his very low self-esteem, his belief that he may be lazy rather than ill, and he added that his mother had suggested he is being defiant or rebellious rather than ill, which he clearly was not. As the session ended he suggested that 'maybe he has put away his feelings for so long and (that) now they need to come out'. I became hopeful for the usefulness of psychotherapy and felt we might be beginning to make some meaningful contact.

However, by the next session (7th), that insight seemed to have submerged and he said things were fine- that he '*can't see how it has to do with feelings - it's just that he has lost his ability to cope*', and that he '*has lost his awareness of his surroundings*' and '*the ability to deal with everyday things*'. Again he doubted his illness and seemed to question my trust in his reports of his illness. This led to a discussion of the types of jobs he might be able to consider doing, but he recognised that to go out and work would be impossible for him at that stage.

In the next session, the eighth, he began to relate some of the psychotic material. He told me of some of the thoughts and dreams and ideas he had been having at the time of his breakdown, and detailed his experience of throwing himself under the truck.
At this point it appeared that he was starting to be able to use the relationship as a container in which to explore the psychotic material - in which case there would have been a real shift, a significant one towards relating the psychotic material to his experience. If this were so, then even in the absence of a strong therapeutic alliance the therapy was beginning to make sense - perhaps there had been some kind of breakthrough!

In the following session (ninth) Jesse seemed quite cut off from what had occurred in the previous hour - and I became aware of a lack of continuity between the sessions. He spoke at length about religion and philosophy and his thinking about these which he had done a few years previously. The crux was that he had ultimately not been able to accept on faith alone and at some point he had reached his own religious conclusions. These differed from those of his mother and this was where the trouble began at home. He was ultimately rejected because of his beliefs.
Was he perhaps, even at this early stage telling me something about how he could not accept my belief in psychotherapy and that he needed some concrete evidence from me so as to be able to sustain his effort - so as to be able to use psychotherapy at all? But of course, I could not give him

this.

The tenth session was one in which I began to get a glimpse of his psychic space through the images he revealed. These were of himself as a desert of endless sand dunes, and as being in a boat in the middle of the ocean without sails or oars, where he knows there is land, but he does not know in which direction it is. We were able to expand and elaborate and work with these images to a point, but then Jesse would say 'it was only a figure of speech' and be unwilling to continue. I will discuss these further below (see 6.2). By the end of this session he said 'thanks' and 'bye' as he left.

In the following session (eleventh) he again said that there was nothing to talk about, and that we never come up with any solutions..... but then he spent 90 minutes with me in which he spoke of his despair, his relationship with his mother and the past difficulties with him that she always brings up.
I had the feeling that Jesse was depressed but he denied any feelings of depression. After 50 minutes I suggested we end the session and he said 'alright', but then continued for another forty minutes.
My countertransference feelings were intense, and I was distinctly aware of an experience of projective identification - where throughout almost all of the session, and afterwards, I felt totally and utterly despairing, helpless, inappropriate and useless. I experienced overwhelming feelings of depression and I desperately wanted to end the therapy.

In the twelfth session Jesse revealed what appeared to be a further disengagement. He said that he had difficulty watching television or doing puzzles, wanted to eat less, *'didn't get anything out of sleep'*, and that everything appeared mechanical.

Again in session thirteen he began by saying there was nothing to talk about, but we had a fairly relaxed hour where we shared a few laughs over a film he had seen and an outing he had been on to the local theatre where he had worked backstage seasonally for a few years running. I think the lightness in this session was a relief for both of us.

In the fourteenth session Jesse told me he had gone into town and felt more competent than he had before. He said that this had been surprising and led him to feeling somewhat more hopeful. He spoke at length about his religious differences with his mother, of his feelings about being at the hospital, and of his hope for recovery - or how he regulates his hope, ie., by considering the possibility that he will never be able to leave. He

spoke of how hard it was to live without knowing for sure what was the likely course of his illness and its prognosis for him.

Session fifteen - Jesse spent the entire session talking of his political views. He spoke logically and coherently and it was clear that his views were intellectually well thought-out and mature. However, I had an inkling of what his mother described as where 'he would talk and talk for hours, and where the family would avoid him so as not to get trapped by his talking'. My countertransference feelings were of extreme sleepiness.

In the next session (sixteenth) we spoke again, and in more detail this time, of his psychosis. We also spoke of his leaving home and what that had meant for him.
Again he spoke about his lack of motivation and I made a tentative interpretation about the possibility that his lack of motivation had to do with fears around doing things which up until then had been his only real way of expressing himself.....and that this was a way of protecting himself from the world and its judgement and possible rejection of him. He seemed very taken with this idea.

However, by the following session (seventeenth) he was unable to pick up where we had left off. He said he had '*felt we were getting somewhere, but that the feeling had gone out of it*'.
Jesse began to talk again about the time he had left home and attempted to assert his independence but as I began to empathize with his difficulties regarding his family, he again became quite defensive, saying that he had had no problems with them. He seemed to become distressed and angry so I addressed these, and while he did not acknowledge his anger directly he talked about being frustrated in that we were looking for problems, talking about things that are not important to him - he said that he 'can't see the point....it's like maths to an Aborigine..... he doesn't want to look at himself'.....
My contertransference feelings were of being extremely demanding and expecting too much of him as well as being ineffectual.

In the eighteenth session he talked about his stuckness - he said that looking at things in his past was all very well but he could not see how this was going to make him unstuck. I addressed the idea of my demandingness and he said he did experience it a little, but that he did not want to fight it and wanted to be helpful where he could. He told me that he did not think about himself otherwise, and also that he never thought about me nor the therapy between sessions and expressed the idea that we could still be doing the same thing this time next year.

At the end of this session he said 'goodbye' and 'see you tomorrow'. This was the kind of gesture that gave me hope that something was happening.

In the following session (the 19th, and 5 weeks into the therapy) he mentioned that the doctor had brought up the idea of medication again and had said that it would be discussed at the meeting the following week. Jesse felt he had tried everything he could to get better, and was willing to try medication at that point although he was not particularly hopeful. He spent much of the session talking about the other patients on the ward and his experience of them. Again we spoke of the therapy and his experience of it and he said he felt it was something with which he could 'go along'.

Session 20- Although there were supposed to have been a further three weeks of psychotherapy before initiating medication, Jesse was put on medication at this point. Interestingly, my comment at the end of my psychotherapy notes for this session is that this was about the best session we had had up until then, in that he had allowed me and himself access to his feeling world in a gesture of openness and trust that had been very warming for me. He had spoken about a relationship with a woman that had 'turned sour'; about how interpersonal dynamics are very difficult for him ie., he often feels that things get misinterpreted; how he had difficulty with trust and that he felt like a social failure.

In the following session (Session 21), he seemed to acknowledge wholeheartedly, for the first time, something I said - about his creativity being the element in his life that was missing. For Jesse his creativity was both the expression of his individuality and also his contribution to the world - both of which he was currently and most painfully lacking. He spoke of the wooden puzzles he used to make and then put away in a box because 'no-one had the time to understand what it was - or they would just ignore it' - something it had taken him a year to make. These are the puzzles I speak of (section 6.2) as a metaphor for his psychic life.

By the 22nd session and after a week on medication, Jesse was not feeling any better. To me he seemed more depressed, but he did not acknowledge feeling depressed - only feeling at a loss. There seemed to be an edge of hopelessness again which had not been there for a while.

In the following session (23rd) Jesse reported that he had found something to do, that he was working with numbers. While he appeared perhaps to be better inwardly ie., he was doing something, outwardly he appeared even more shut off than before. He was spending more time alone in his

room and the ward staff said they found him more withdrawn. His mother had visited the previous evening and suggested that he should see a minister rather than a psychologist.
Psychotherapy seemed to have drawn to a halt at this point. My feeling was that he had backed off from his real feelings of despair and was waiting for the medication to work, perhaps we both were, but without much hope it seemed.

Jesse began session 24 with a discussion on his thoughts about the centre of gravity. He revealed a theory he was working on but with which he currently felt stuck. The stuckness seemed to relate to the position of his feet on the ground. He said that he could not figure out the starting point or the point of departure, the ground from where it is possible to measure the centre of the earth.
Later in the hour he spoke about doing chores at home, and how he and his mother had different ideas about what needed and did not really need doing - ie., he only considers the necessities, whereas she is concerned with the 'decorations'. He also said that these chores would interfere with his free time so he would rebel. When I reflected the idea of the quality of her demands as an impingement for him, he quickly retracted, and when I addressed this he assured me that things were <u>really</u> not that bad, that if the chores got done quickly he did not mind doing them at all, and in fact, he was the one who enjoyed doing the worst jobs, like cleaning drains.

In the 25th session, Jesse spoke of his past difficulties in terms of a career choice, saying that now that he could no longer do what had seemed right for him, there was nothing for him at all. He felt it was because he was incapable of finding his own direction that he had turned to God for help and guidance. He said that he had had direction previously from the structures provided by the rulings of school, his mother and God, but without these he was lost- he was completely without any drive. He expressed a wish to be inventive or creative, but acknowledged that these were things one can wish for, but not make happen. Jesse denied that being at a loss in this way was a problem, and only acknowledged that 'it was a bit long now'. He spoke of his dislike for anything negative, especiallly negative feelings. He said that *'in the family it was a case of perseverance, lots of work and things come right in the end'.*

Session 26 - That morning as I arrived at the hospital, Jesse was sitting on the bench outside my office waiting for me with one of his puzzles that he had fetched from home on the weekend. It was very beautiful and I admired it, and later, when he came to the session he brought another two puzzles which he had made. This led us to talking about his creativity and

how he had lost it and what that was like. He talked about not being able to understand feelings very well and said that his 'outlet' or his 'connection' was the 'practical world' - as that was safer.
At some point he brought up the image of a ship without a captain and not knowing which direction to take - at which I gently suggested it could be inwards, to which he responded by saying that it was very difficult, but perhaps I knew better. He said he would be willing to try but that he was not sure how.

By the following session (27th), he seemed discouraged again and even irritated- he said that there was no apparent progress, that he felt at a dead end, that talking was not getting him anywhere and that it was difficult and awkward to face it all the time- having to turn over the same stones again and again.

By this session (the 28th, and three weeks into his medication -and after it had been changed at the recommendation of a visiting psychiatrist) I was becoming aware that there had been a further change. A few weeks previously I had felt that he was beginning to connect with me and work in psychotherapy, but now he was not. The therapy had really flattened out and it seemed that there was nothing to work with - I felt no connection any more with Jesse. He was rigidly intellectualising at that point and becoming even more withdrawn. In short, the medication was not helping Jesse in any way and also seemed to be interfering with the therapy.

In the 29th session Jesse seemed more depressed and more despondent than he had been up until then. He said he thought the first type of medication had possibly been slightly better than the current one, and told me that it was going to be changed again.
He spoke again of his 'inertness' and not knowing what caused it. I will insert a short exerpt here for the reader to get a sense of the quality of Jesse's world at this point.
**Patient**: I don't know whether it's psychological or mental, but finding pleasure in daily living just isn't there .....*pause*.....I suppose it's lack of feelings that causes it because feelings are what make life interesting ..... *pause*..... I've been trying to think about feelings and what they have to do with my situation, and it's more to do with.....there's nothing- the depth of feeling isn't there.....*pause*..... Feelings give a thing quality even though it's something simple..... But the whole thing doesn't work.....*(section omitted)*.....It feels stalematish or awkward.
He again spoke of his lack of social interest and inability to offer anything. We talked about what that meant in terms of the therapy and he said it was difficult to come every day, but it was alright in the sense

that I did not expect anything more from him than he could manage. But he added that he would still like to see things improving - which they weren't.

Session 30. In this session Jesse told me that his mother had visited and offered that he go home, be part of the family, be a Christian, do things with them and not be passive - but that he had told her that he could not and she had accepted. He said that it was nice to know he could go home - but that in order to do so he had to be living. He told me he had listened to a discussion on depression and recognised that he had all the symptoms of depression although he did not feel depressed. Finally, after expressing surprise that no-one had labelled him depressed, he recognised that calling his state 'depression' did not make it any different.

In the following session (31st) he described a nightmare he had had as a child which he said he thought I might find interesting. In the dream he had been trapped in a 'mushy blackness', in which he was 'rolled up like in a carpet', and which was spinning round 'like washing in the barrel of a washing machine'. The blackness changed into a spinning whiteness which stretched out into the horizon. I attempted to work with the feelings but he could not describe anything further than 'scary' or that he was 'afraid' since it was dark, and he was in his bed and it invaded his safety, as his bed was his island. This led to an association of drowning, and he said that he had asked his parents if he had had any such experience (he had not), but when I suggested that perhaps he had felt in some other way that he was drowning, he was unable to take the idea any further. The dream will be discussed further under section 6.2 below.
Jesse spoke of being very 'switched off' as a child, detached and just existing in his own world. He said that although it was 'his world versus the world around him', the two were not in opposition - that the only opposition was his mother, as she tried to make him more 'normal'.
There were many long silences and Jesse yawned repeatedly throughout the session.

In session 32 Jesse said he felt that he had stopped functioning altogether. He spoke of this stuckness for a long while and then also spoke about his relationship with people as follows:
**Patient**: I like people, and I like women too, but I just sit on one side and don't join in..... I've got nothing to say really..... I don't move in that sphere at all.....I don't want to chat or 'get on'.....*pause* ..... I would like to share things but I'm just not there.....*(section omitted).* You can like people but nothing ever comes of it, you just like somebody and so what.....you can't do anything or help them or communicate that you like

them.....I could say that I like you but now what about it?
**Therapist**: It would give me a warm feeling, and that's something..... *pause*.....I really like you, Jesse. *(As unlikely as this might seem, given how the therapy had been going up until now, I felt absolutely congruent saying this. I really did like Jesse, as did many of the other patients , my colleagues and the nursing staff also).*
**Patient**: Well, it doesn't give me a warm feeling, it's easy to say, but I live in the practical world.....*(section omitted)*.....it's too easy to say and not mean..... *long pause*.....
**Therapist**: It's hard for you to trust whether people mean what they say.
**Patient**: Well, yes it is.....it's very difficult.....(He spoke about actors with empty words and his difficulty in trusting people).
He also spoke of the time he had been reevaluating his religious and philosophical ideas and asserting his independence as a disaster - he said that he had timed his letters home to his family about his new thoughts and ideas very badly and the whole thing had 'blown up'. He insisted that the fact that things had fallen apart for him was not their fault.
Again we discussed therapy and he said he felt absolutely no connection with me, that he did not enjoy the time and did not look foward to coming at all. Because of my countertransference feelings of demandingness and of expecting too much of him, I again suggested termination but he said he did not hate coming either, and he was not sure if he would miss the sessions if we stopped. I was due for a week's leave so we decided that he could see how the break felt for him and then decide whether or not to terminate.

By the next session (33rd) Jesse reported that he had reached rock bottom. However, we had what seemed to me a much warmer session where he spoke about a girlfriend who had written him a "Dear John" - at which he had felt very hurt. He told me that he slept a lot and 'switched off' as he has now. He said that he realised at that time that he had interpersonal difficulties. I felt that we had connected a little again but as the session ended he requested that we reduce the frequency of the sessions - since we were not 'getting anywhere'.

In the 34th session Jesse said he was feeling a little different - perhaps like living a little. He expressed concern about wasting my time. He spoke about missing being needed and needing people in return, about having no needs and this making him feel lonely because he cannot make contact - that even when he speaks to people he feels no contact. Again he spoke of the incident with his girlfriend and how he feels he has never got over that. I had felt a little more connected to him again in this session.

Session 35- Jesse was feeling totally amotivated and also more hopeless, saying he wished there was a switch that would go off by accident and end it all since he did not have the guts to commit suicide. At this point I noticed quite a striking discrepancy between what he reported to me about his behaviour and the way he appeared to be socialising on the ward. He would 'hang out' with the other patients, go for walks and spend time in their company, particularly with a rather histrionic female patient of approximately his own age. To my observations he replied that he would like to be able to talk to her but could not, and that as far as the other patients were concerned he did have likes and dislikes, but that was as far as it went.

In session 36, Jesse appeared even more depressed and hopeless. He spoke about the therapy as a way of passing the time and said that when it was over he would just go and sit around somewhere else. He also said that he gets as much from talking to the patients on the ward, and that he draws energy from them. When I spoke of the connection I had felt with him in speaking about his girlfriend, he said that he had just been relating a story, it was a puzzle he had looked at a long time ago and become bored with and since put away and forgotten about.

Perhaps the reader will ask why we did not terminate when things appeared so hopeless and the therapy appeared to be making no impact whatsoever. By now we had had 36 sessions and it appeared that no therapeutic relationship had yet developed and that no progress at all was being made - Jesse's symptoms seemed totally and frustratingly immovable. I was certainly thinking of termination, and I even think we were both wanting it..... but somehow we both clung on.....I'm not really sure why. It seemed that every time I suggested we terminate, he would hang on and not take up this offer, and if I said nothing then he would want to end the therapy. I will comment below (in section 6.5) on the ambivalence of both the patient and the therapist which is quite clearly illustrated in the sequences of the past few sessions (ie., ±32-40).

Session 37- Jesse spoke of his feelings of total hopelessness, yet saying he could not think of a way to end it all and so would sit it out as long as possible. He offered to go over his history again since I seemed to find this useful, but admitted he really could not see the point, at which I declined his offer, and we ended the session after about 10 minutes.

In session 38, when I suggested termination again, he said he would be sorry to lose his contact with the staff (meaning me), as he never spoke to the nurses. This session had been scheduled as a 10 minute 'chat', but he

used the full time talking about his dialogue with God and the hallucinatory voices which had told him he deserved to die -that he had to be a sacrifice for humanity. He said he had contested this and fought against it. Although he had thrown himself under a truck in the end, he said it had not been his doing.

Again in the following session (39th) we discussed termination - this time Jesse brought it up. I agreed we could terminate but suggested we meet twice more for 5 or 10 minutes in case there was anything that had been left unfinished. To this he replied it was like flogging a dead horse but agreed, good-humoredly, to come along anyway. He commented on what he first called my patience and clarified as my loving and caring.
Again he used the entire session- talking about his mother and their clash of wills, and his having decided to put aside his feelings for hers, that hers were always more important, and assured me that although that sounds bad, it was not. I perceived some of this ie., the clash of wills, as a transference issue, and picked it up as such, and although a 'clash of wills' was clearly being acted out in our interactions as regards termination, Jesse did not respond to my interpretation and denied any connection.

Session 40 - Jesse did not arrive and I went to collect him in the day-room where I found him knitting. He mentioned going to a village settlement for mentally retarded people although he was not sure if he would be accepted there. He said his parents are still quite optimistic but that puts pressure on him to which he cannot respond. When I mentioned we would only meet once more, he said he would like to continue once a week as he could not think of anything better to do with his time. He said he would like to have someone with whom he can bounce off ideas, like today - about leaving, although he did not really see how he could leave.

Session 41 -Altogether Jesse seemed much brighter as there had been talk of sending him to the village settlement and he was quite excited about this, although he did not have much confidence in his ability to cope there. He expressed a willingness to experiment further with drugs and a respect for 'our' opinion of what might be good for him.

The following session (42nd), a week later, was our last session as his parents were to take him down to Cape Town the following day. He was very excited and said that he was feeling about 50% of his normal self again. He had shaved off his beard, a sign (he had told me previously) that he was feeling better - although he did not know what had made him feel better. (The medication had been changed again by this time). He said how

much he appreciated his parent's support and mine, and said that what had been most important was that I had let him be where he was and never put pressure on him to get better like everyone else did.
He disclosed to me a commercial art project he had thought up some time ago and was now bursting to get on with and wanted me to join him in doing. He said really sweetly at some point *'one thing's for sure, I'll miss you'* - wished me luck and said he thought I'd make an excellent psychologist.

Just before leaving early on the following day he came across to the outpatient centre where I was working to say goodbye.
As we shook hands he said: *'Thanks very much, it didn't help, but I enjoyed the contact'.*

I guess that about summed it up - or did it?

As I review my therapy notes, the therapy appears to have done all the 'right' things, ie., accessed all the issues with which a psychotherapy or psychotherapist is generally concerned. We discussed the past, his early history, made historical or genetic links as well as horizontal ones; transference issues were addressed appropriately as far as possible, as were my countertransference feelings, ie., in supervision; we worked directly with the psychotic material; I was mostly cautious and fairly conservative with interpretations, but also addressed some critical issues in this way; I was able, with the help of my supervisor and a colleague to be mostly optimistic; addressed his ego with respect - as authentic and genuinely human and one with integrity, as Perry (1980) suggests; we spoke about feelings, reached the hopelessness and despair at times; we were together both in dialogue and in silence; we spoke about his relationship with his mother and some of their difficulties - and yet, throughout the therapy I felt, in fact we both did, that nothing was happening therapeutically.

The question then is - why did it not help?

What was it that was missing, where was the lack, the basic fault, the missing link.....

These questions bring me to the essence of this work, and that is to try to formulate some ideas about why psychotherapy apparently did not help.
I shall discuss some ideas below under section 6.0 of this project.

# CHAPTER 6

## 6.0 DIFFICULTIES IN PSYCHOTHERAPY WITH A RESIDUAL SCHIZOPHRENIC

### 6.1 The Therapeutic Relationship - or Absence of Relationship

Although a discussion of the psyche is not intended as the thrust of this work, it has become central in my mind to providing an understanding and a framework for my discussion.

I have indicated above (section 1.0) that it had come to mind that there was some essential of the human order that seemed to be missing in Jesse, and which was apparently making psychotherapy impossible. Jesse often spoke of 'something missing' and in session 21 we named it his 'creativity' that was missing, and, as already mentioned, this was an insight which really seemed to fit his experience. I will attempt to link these two concepts in terms of the work of Michael Balint (1968) and expand it in terms of the implications for psychotherapy as proposed by Khan (1969) in his essay on Balint's work.

Balint essentially describes two levels of functioning. Broadly, these are the œdipal level, and the level of the basic fault. The implications for functioning at these different levels are in the areas of object-relationships and conflict, and for communication and language.
Balint's basic fault is described as 'a fault in the basic structure of the personality, something akin to a defect or a scar which amounts to something wrong with the mind, a deficiency which must be put right, something missing.....' (Balint, 1968, p.88).

There is, however, a further and even more primitive level of functioning which also has far-reaching implications for relationship. Balint (1968, p.24) writes:
'Whereas the area of the œdipus conflict is characterised by the presence of at least two objects, apart from the subject, and the area of the basic fault by a very peculiar, exclusively two-person relationship, the third area is characterised by the fact that in it there is no external object present. The subject is on his own and his main concern is to produce something out of himself'.
However, at this third, and genetically earliest level, the subject is not totally alone, because what Balint calls 'pre-objects' are present. Balint says these are very primitive and unorganised and difficult to language, but that the process of transforming the pre-object into a proper object occurs through the area of creation. Likened to artistic creation, some

other creative acts are 'mathematics and philosophy, gaining insight, understanding something or somebody, and last but not least, two highly important phenomena : the early phases of becoming - bodily or mentally - "ill" and spontaneous recovery from an "illness" ' (Balint, 1968, p.24). The difficulty with the person who functions at this level is that since no external objects are present, therefore no transference relationship can develop. Khan (1969) gives Balint's example of the silent patient who 'is creating something which we cannot know of.....nor can he share it.....but (where) we can be with him and watch him from the outside during his work'.

Khan (1969) asserts that for the patient functioning at this level, any possibility of creation is destroyed by what he terms 'attention-seeking interpretations' which are experienced as intrusions by the external object. He expands this notion to include 'the provision of failure' where he says the therapist must 'fail (the) patient in the service of the patient's growth' by witholding his contribution, so that the ego functions 'can crystallise out of the area of creation'. Khan writes that the idea of failures in the therapy is 'intimately related developmentally' to the idea of 'creative disillusionment' which involves the inevitable occurrence of failures in the early maternal holding environment, and are imperatives in ego development.

Jesse often spoke of his way of expressing himself and his communication with the world as being through 'doing things' - even remarking that it was the very essence of himself, the thing by which he defined himself, and that which was most important to him. It seems that it was his ability to do things that gave him his identity and his sense of purpose and meaning - and it was this that he had lost. It follows, then, that when he became psychotic, and had what he described as an 'identity crisis', and that it was his 'identity', his 'self', his 'ego', his 'soul', his 'I', that he had lost or which was missing - what he had in fact lost, was this ability to be creative, by which he defined himself.

It is my hypothesis that perhaps Jesse had never really left this pre-object world, but always, and almost exclusively, lived within the very primitive area of creation in which he had some possibility of survival, some frame of reference, at least a semblance of ego function - all the while struggling to create his self, but which had, nevertheless, not yet crystallised. A death to his creativity then, is also a death to his primitive, as yet unformed, tenuous self. In session 18, I interpreted this by wondering out loud that it was interesting that it was exactly what was most vitally important to him, ie., his ability to do things (be creative) that he had lost. Jesse responded by saying that this was not what he would have chosen or masterminded but that there was nothing

much he could do about it. He talked about being up against his destiny and of life as an uncertainty, saying that the real trouble was that he is always more and more the slave rather than the master of his destiny.
In terms of the above conceptualisation, where the inability to be creative annihilates what fragile self exists, it is not surprising that Jesse was left so devastated. Whether this ultimate surrender of the self and of the stuff with which it was made, its very fabric (ie., his ability to be creative) was a defensive act, and one, which in terms of his family and environment, in itself was creative and therefore to be respected as such, must remain speculative. I can only say in retrospect that by interpreting the defense and providing my understanding rather than witholding it and allowing him to create his own understanding, and on his own terms, that perhaps I failed to fail my patient - and in so doing, failed him.

Further to this, the above formulation also elucidates Jesse's extreme lack of subjectivity in the world. There can be no subjectivity where there are not yet objects. Is is any wonder then, that Jesse was so psychically dead to the world, to feelings and most especially to relationship?

While I had clearly heard and understood his words it seems now that what I must have somehow missed was the absolute depth of this lack, or what was missing. I had, perhaps naively, assumed that there was at least some modicum of distance or symbolic space between his words (the language he used) and the loss of which he spoke. But now it appears that perhaps I did not. I had not understood what it really meant - the level of existence where object-relationship is neither dyadic nor triadic nor even part-object, but pre-object and, it follows, presubjective. Is it any wonder that while Jesse was so stuck in this lifeless world that no psychotherapeutic work could occur?

The reader might argue at this point that Jesse was not pre-object in the sense of having no relationship with the world, but rather, that he lived in a world of lifeless objects, and that even though there was no psychotherapeutic or transference relationship which was experienced by his therapist as such, that he was still a being-in-the-world, and that he did have a relationship with me, whatever its quality, or depth, or meaning- or lack of these. This, of course, is true. It is not possible to say that there was no relationship at all, and perhaps I may have overstated the above (pre-object) formulation, but it is also true I had virtually no experience of myself as, or being used as, any type of object in Jesse's world.

To clarify, Bollas (1987, p. 241) describes what he terms transference

positions, which are defined by the particular use the patient makes of the therapist and the therapeutic process at any one time. There are several ways in which the patient uses the therapist as object, or in which these transference positions are enacted. I will not describe them here. But very briefly, these usages are separable into two classes of transference relationship; (i) where both the patient and the therapist are involved in the patient's projections and introjections which are lived out in the relationship (ie., where the therapist is an internal or external object); and (ii)where the patient makes use of the therapist 'in a private, often unknowable, self-experience within the therapy. The patient uses the therapist as an auxiliary to the process of knowing the self'. This way, the therapist as an object is neither strictly internal nor external, but 'transformational' (Bollas, 1987). He suggests that in order to ascertain how we, as therapists, are used as an object at the precedipal level 'we must turn to the countertransference and ask of ourself, "how do we feel used?"' (Bollas,1987, p.203).

If I answer as truthfully as I can, I did not feel used in either of the ways described above - I was not used as a real object -since Jesse showed an almost total inability to relate to me as a real person, in that his projections and introjections were not lived out in the relationship, and neither did he appear to use me as a maternal or holding presence, as an empathic ambience or Bollas' 'transformational' object.

Then what was the nature of our relationship?

I will try to clarify my experience of the lack of relationship further. McDougall (1973; Green, 1987, p.37) describes what she terms the 'anti-analysand' where the patient is unable to enter the analytic process, and 'the transference is stillborn despite the analyst's efforts to help or even to provoke its appearance'. She says that 'the analyst is caught in the patient's mummified objects, paralysed in his activity and unable to stimulate any curiosity in the patient about himself'. The analyst's position is then one of 'object exclusion'. This kind of social 'normality' in the analytic process with this person is seen as one extreme (as opposed to the fusional regression and object dependence often seen in borderline states) in the 'contemporary scope of analysis' (Green,1987), and is echoed in the description of the 'normotic personality' to be found in the writings of Bollas(1987), (see section 6.3 below).
Of the above formulations, McDougall's 'object exclusion' seems to elucidate, to some degree, my experience of the relationship with Jesse, and Jesse's apparent non-use of the therapeutic encounter or objects.

Modell (1969, p.35) says that the medium for the creation of both the transitional space and the image of the analyst as transitional object is the transference relationship - and that these transitional phenomena are created in accordance with need *(my emphases)*. The transitional human object then stands between the patient's inner world (chaos), and the environment as an illusory protective shield. However, this formulation presupposes the ability to create, the presence of objects, an inner world and also a state of need. I have already discussed the two former and will now address the latter with an illustrative example. The third will be addressed in the following section, (6.2).

At some point during session 34 Jesse was silent a long time and then he said:
**Patient:** I've been thinking,.....in a sense what I miss is being needed by people but at the same time needing people in return.....yea.....um.....you know, because there's nothing I can do really, and there's nothing I can need people for.....um.....you know, .....*(section omitted)*.....it's just not there.....
**Therapist:** There's no need inside of you.
**Patient:** Yea.....so I miss the people - if one wants to put it like that.....it's like.....yea.....its like feeling lonely.....because one can't make contact.....*long pause*.....
**Therapist:** What happens if you try?
**Patient:** I don't know - I don't try really.....there are no lines to try along, if one wants to put it like that- I've got no means at all really to establish contact.....I can do small things like carry plates or share out grapes *(ie., chores on the ward)* but not make tea.....*(section omitted,* .....because I don't drink tea.

Jesse's statement about missing people, rather than being expressed as a need or as a desire, or with sorrow, was stated as one would any piece of objective data or information, as a given, as a fact of life, and as something which did not really, intimately concern him. It is hard to put into words the kind of rigid, intellectualised and even ruthless objectivity with which Jesse was living, but this comes across more readily through his mostly toneless voice and often expressionless face.

If it is as Modell (1969) suggests, that transitional space and objects are created out of, or in accordance with such needs as arise during the time of the development of the ego and the emergence of the self as separate, (and as the writings of such eminent thinkers as Freud and Winnicott and others have clearly documented), then it stands to reason that for Jesse, in whom no experience of need or desire exists, no transitional phenomena

would be created, even if his creative ability was not diminished - and of course, it follows that the transitional or holding capacity of the therapeutic environment as 'the valuable resting place of illusion' would not be needed and therefore never created (Winnicott, 1958; Plaut,1966). Without any need for a holding environment, and without the ability to imagine or to be creative, the therapeutic relationship could never be established and neither could any therapeutic work occur. At least, this was our experience (mine, and that of my supervisor), although we did not formulate it in this way during the course of psychotherapy.

For Plaut (1966), however, as well as the ability to imagine (an essential for the creation of transitional phenomena and thus for the development of the transference relationship), the capacity to trust is a further precondition for ego development. Plaut endorses the idea of imagination and the ability to trust as intimately linked, if not identical, and describes both as being disturbed during pathological early relationships. A failure in this capacity 'impoverishes life and requires careful transference analysis in order to further the ego's function to trust both in relationship and in imagination'. Plaut (1966, p.130) asserts that a person who suffers an absence of imagination is not necessarily 'unanalysable', but that through the analysis of the transference 'the deepest layers of the psyche are reached and connected with the ego when imagery becomes associated with experiences'. This experience of 'the past in the present' is achieved through the 'holding' which occurs in the transference. However, there are many examples of Jesse's inability to experience 'the past in the present', such as when I commented that I had felt he was connecting with his experience when he was speaking about the "Dear John" letter he had received, and he responded that it was just a puzzle he *'had tried to sort out, but had got bored with and put away a long time ago'*. Similarly with his psychotic experience which he seemed to be able to dismiss as *'something in his imagination'*.

Through all this, I am left wondering how, without the capacity to imagine, can a transference relationship develop? Does it not, at its very essence, require that we live in a human world - a world of subject and objects, a world of language, of symbols, of feelings, of relationship, and of the depths and heights of spirit and soul?

Let us now look further, and more graphically, through the use of images and a dream, into Jesse's pre-subjective world.

## 6.2 Psychic Space or World as Described Through a Dream, an Image and a Puzzle

From the above it must already be clear to the reader that Jesse's psychic life was impoverished in the extreme, that it was one without richness, depth or colour, one that was lacking in differentiation, dimensionality, contrasts and ground.

Jesse attempted to describe his world in many ways but it seems to have best been captured through a dream, an image and in the metaphor of the puzzle.

In a dream (a recurrent childhood nightmare) related in the 31st session, he described being rolled up and trapped in a 'mushy blackness' as in a carpet, it was '*like in the inside of a washing machine where everything goes round*'. He was caught up in this and it would go turning round, and after a while it would stop - '*and everything would go like a white sheet, not a sheet but you could feel that everything was stretched - you could feel the tension and everything went flat all around me*'. He would then wake up frightened and start crying.

In working with the dream Jesse elaborated as follows:
**Patient:** .....I don't know why, what exactly was the cause, just maybe the.....er.....going-on's inside my head, and the dream.....it was..... yea.....difficult.....I don't know, I was.....trapped. *(Section omitted)* It was scary.
**Therapist**: Do you have any memory of what it was that you were afraid of?
**Patient**: It was the dream itself.....you know.....just the situation.....I suppose because it was dark, and I was in my bed and stuff like that, you know.....I suppose it invaded my safety - your bed's your island..... yea.....um,.....no, I can't say why.....*(section omitted)* ..... it wasn't familiar.

Romanyshyn (Rhodes University Seminar, 1990) described three characteristics of the spatiality of the schizophrenic style. These are: subject-object space - which relates to the subject-object dichotomy or the issue of boundaries. It is where the world has fallen away, and there are no anchors or connections and nothing is familiar. The second aspect of schizophrenic spatiality concerns the shrinkage of space -where the world is reduced to the area of the body, and also where the ego is the fragile, bodily one of infancy. The third is the invasiveness of space - where space, or the world, becomes a threatening, intrusive, invasive

object, and it becomes increasingly difficult to keep differentiation, with the result that boundaries slowly fade.

Through the image in the dream and the little vignette above, all three characteristics of the schizophrenic spaciality, as described by Romanyshyn, are clearly embodied.
I do not think I need to elaborate these any further. Jesse clearly lives in a world in which he is helpless, trapped and suffocating. A world which is formless and where he is without any ground. It is a world which presents as invasive, intrusive, hostile, frightening, uninhabited and unsupporting- a bleak, black-and-white, undifferentiated, alienating, lifeless world, and one that has perhaps also been present since childhood.

The images which best seem to describe his world were those he revealed in the 10th sesson where he spoke of himself as a desert where there were just endless sand dunes. This image changed during our dialogue to one where he was in a boat in the middle of the ocean, and where he has all the charts but there is no wind, no sails, no oars - where he knows there is land but he does not know in which direction it is. He clarified later by saying he had some hope - that he knew there was a way for him - if only he could find it. This image recurred in session 26 but this time he said he was *'like a ship without a captain'*, and that he did not know which direction to take.
Here the image reveals an undifferentiated sand or seascape - devoid of any shape or form, unpeopled, desolate, barren, bleak, impossible!

At some point in working with this image, Jesse said after a long pause:
**Patient:** I don't know what to do any more - which direction to take.
**Therapist:**.....*pause*..... I wonder if perhaps the direction is inwards.....
**Patient:** Well, yes.....maybe.....but it's very difficult.....but perhaps you know better.....*pause*.....I've got no more ideas, so you must go after what you want.
**Therapist:** You want me to do all the digging. *(We, or rather I, had spoken earlier about digging up the roots of a tree to find the source of its dying).*
**Patient:** Yes, you have to do all the digging *(laughs)*.....since you seem to know what you're looking for .....

Comment: Is not the communication through these images perhaps that there is nothing inside - and that this makes it impossible - or, at the very least, incongruous to go in?

The image of the puzzle was one which recurred through the therapy, not as a figure of speech, but more as a kind of barometer or a concrete

metaphor for Jesse's life-space. Bollas (1987, p.137) says that the normotically* disturbed person houses various aspects and functions of his internal or psychic world in material objects, and that 'even though they use these objects and collect them into a familiar space, they serve no symbolic purpose'.

When I first met Jesse he would sit all day long doing jigsaw puzzles. As his enthusiasm for life dwindled and his energy in psychotherapy waned, so did his enthusiasm for the puzzles. As an adolescent Jesse loved to make puzzles out of wood. These were 3-dimensional puzzles which he brought to show me - they were beautifully carved and intricately fitted together. Jesse said he would carefully and painstakingly make and proudly show them to his parents- but that no-one really had the time to understand what it was- or they would just ignore what he made so he would lose interest and put his creations away in a box. Using the puzzle as a metaphor (and as an act of creation) Jesse describes his pre-psychotic life as 3-dimensional. Was he not saying something here about how he had put away his own 'dimensionality' in the same way? Was this not also a communication about how he had put away his creativity, and with it his vitality, his 'three-dimensionality' - and was now living in a unidimensional, undifferentiated psychic space - that his life too, was a puzzle in which he had lost interest and put away in a box/coffin, a life that had to be hidden away and was forgotten?

And is not the further communication then, how can he possibly be motivated if he lives in such a world? There is no sense in, or possibility of being motivated in such a world, since motivation comes only once there is differentiation in landscape and one has some ground (Romanyshyn,1990). The only surrounds or landscapes of his existence are endless sand and water, a dark, forgotten box and a spinning whiteness!

Two concepts come to mind when thinking about this psychic 'death'. The first is one proposed by Karon & VandenBos (p.48) in describing schizophrenia as a way of coping with a terrible world. They liken the well-documented 'immobility response', which occurs in most species of animals when under attack by a predator to the catatonic stupor, in that both are involuntary, emergency reactions, and a defense against imminent death. An animal in this state can endure great pain and appears dead, to all intents and purposes. While the catatonic stupor is a more bodily, or physiological experience, a psychic 'death' would have a similar function, in that it would protect the individual from what is experienced as a

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*See definition on page 60.

threat of real death or, in fact, a fate worse than death, and in this case what De Waelhens (1978) calls scission, or separation, (the original separation being from the mother at birth) which, he says 'is precisely that to which the schizophrenic can never consent at any price' - for it is by definition a state of lack. The existence of this state of lack reflects the mother's inability 'to give meaning to giving birth' and results in 'both lack(ing) the distance created by the acceptance of some signifier to signify the event of birth'. De Waelhens (1978) terms this lack of distance one of the structural characteristics of schizophrenia. I will make a further link with this idea by giving an illustration from the case material.

An aspect of Jesse's delusional thinking which I found written in his hospital file and which he later dismissed as *'just his imagination'* was recorded among various verbatim examples of delusional material and went as follows: *'I've got to give them freedom - this woman I have been excommunicated from'.* There was also an example of an olfactory hallucination - ie., the smell of a woman's uterus.
Perhaps connecting these is taking things a little too far, but De Waelhens (1978) says that the schizophrenic fantasy is that death is a return to the state of non-scission with the mother's body. Was this perhaps a call to the womb, that is, to his long desired birth which is seen to be 'beyond (the) death where he now flounders or stagnates' (De Waelhens, 1978, p.148). In two senses he had been excommunicated; i)by being born (psychologically) ie., creating a separation from his family in making his first independent life-decision by leaving home; and ii)in structuring his own religious belief-system and rejecting his religious upbringing, he would be 'excommunicated' (theoretically) from his church and also from his family, especially his mother - she clearly stated that she could no longer accept him into her house.

De Waelhens says that the idea of birth beyond death is often implicit in the schizophrenic's confusion between birth and death, and that resurrection is often a prevailing theme. Is this then perhaps a second sense in which he had to die, in order for his resurrection to occur?
In Session 38 Jesse had spoken about his dialogue with God and the hallucinatory voices which had told him he deserved to die -that he had to be a sacrifice for humanity. Was this his own humanity for which he had to die? It appears possible - since through his psychosis his mind went 'crazy', his body went 'under a truck', his spirit or his motivation became nonexistent and his soul or feelings disappeared. His psyche, or his psychic life was indeed sacrificed, and his body, almost. Jesse said he had contested his dying for humanity and fought against it, and that although he had thrown himself under a truck in the end, it had not been his

doing - he felt that he had been pushed from behind.

### 6.3 The Therapeutic Relationship - Absence of Mirroring

Benedetti (1975) names the 'mirror-phenomenon' among four curative factors in the psychotherapy of schizophrenia. He states that 'mirror-relatedness' is a psychostructural factor of the healing relationship and is one of the factors which make possible a new openness of communication between patient and therapist. He claims that the mirroring which occurs is a two-way movement - that patient and therapist each become a mirror for the other ie., 'the therapist becomes an integrating mirror of the patient's disintegrating ego and vice-versa..... the patient becomes a mirror of the therapist'. In this way the therapist mirrors not the grandiose self (since there is no grandiose self or ego to be mirrored) but the patient's future cohesive, integrated self, organised within the therapist's unconscious. The therapist absorbs the image of the patient and transforms it and, after a while, gives it back. Over time, the therapist can mirror to the patient his own (the therapist's) changing self-identity. This process begins when the patient is ready 'to become "caught" in the therapeutic mirror, which does not appear in opposition to the schizophrenic existence, but forms itself within the identification with it'. For Benedetti (1975), this process is the reversal of the psychotic process in which the patient 'lives with an alienated mirror of himself'.
Benedetti (1975) prefaces his discussion of curative factors in the psychotherapy of schizophrenia with the idea that to speak of these may be presumptuous, and clearly, for my patient, neither was the dynamic of the therapeutic mirror evident, nor was there any cure. I only know that my patient gave me nothing of myself, and it was also clear that he could take back nothing of himself from me.

Was there so little self that he was invisible to himself? Had he never had any mirror? Was his mirror irreparably broken? Had he stepped forever 'through the looking-glass?'

De Waelhens (1978, p. 136) speaks of the mothers of psychotics as being laws unto themselves, and says that where the mother cannot give up being fulfilled by the child (who is her Other and also the Other to his physiological reality - rather than the physical being that he is), the paternal metaphor is foreclosed and the child is without 'any other signifier of himself than the one of his chaotic immanence; hence, any identification of himself with himself will always be prevented, beginning with that of his mirror image.....he remains fixed in the role of annex to the mother's body'.

While I am at once concerned with not laying blame, and also with understanding, could this conceptualisation not help explicate the absence of mirroring in my patient - prevented by a mother in the hope of keeping her firstborn male child, whose moment of conception she claims to know, in her orbit - ie., with 'the child as phallus of the mother, for him as well as for her?' (De Waelhens, 1978, p.137).

Although in another, and somewhat different context, but which is also relevant to my patient, (in that both these types of patients experience a failure in the capacity for symbolization (see 6.4 below)), Bollas(1987) describes what he calls normotic illness*, where there is an absence of subjectivity or rather, an extreme objectivity - to the extent that even the self is not perceived as a subject but as an object. He continues to say that a person who 'does not perceive himself as a subject does not ask to be seen by the other, nor does he look into the other'. While I see Jesse as possessing something of the quality of the normotic, it is not in every sense of the description. But there are common elements which help to make sense of the absence of mirroring and which, to my mind, interfered with the therapeutic relationship.

* Normotic Personality :....."fundamentally disinclined to experience the subjective element in life, in himself or in the other"; he is interested in facts, takes refuge in material objects, has an identity which seems artificial - "as if no mental work has been employed in the historical fashioning of this identity", is attracted to those like himself who do not threaten his subjectivity; can have a sense of humour, but 'slows down' rather than experience sadness; "action" is the quality of life for him - he appears empty and robot-like, but does not experience want within himself; he may be quite extrovert - but has very little psychic life; he is not known and reflected by the other, deficient in insight; unable to introject and project, therefore unable to identify with the other and limited in empathic capacity".....etc. (Bollas, 1987).

Bollas (1978, p.153) suggests that a patient who neither introjects objects, nor projects himself into objects, has a mental life which is characterised by incorporation and excorporation. Incorporation occurs through the senses and, as it is non-representational, the therapist as an internal object is meaningless, since no thinking or imagination or symbolization has occurred - and therefore no dynamic, internal relationship between the internalized object and a part of the patient's self can develop.

According to Romanyshyn (1990), to live in a human world is to live with a mirror where we see ourselves as others see us and where we reflect back to others how we see them- but from what he understood of Jesse there was no affective mirroring, no mirroring bond - that I, the therapist did not touch him, and he gave me back nothing of myself. Romanyshyn says that the schizophrenic has no mirrors, to reflect weight, or to balance the

significance of thoughts and dreams, and that he then becomes a stranger to himself and cannot read the other. This meant, of course, that he could not be prodded in a human way, could not take anything or any direction from me, and that the only direction he could take or that made sense to him was from on high, or from God.

Is this what Jesse meant, perhaps, when he said (in session 41) that his mother was always behind him with a big stick, but when he left home she was not, so he asked God for meaning, and when God could not give it to him he turned to the land, but that also did not work out - and that he could see how that was a turning point?..... (it was after that that he became psychotic).

### 6.4 The Relationship - Absence of Symbolism

I have already described Jesse's lack of subjectivity and the implications of this for the therapeutic relationship with regard to mirroring. A further consideration in terms of the therapeutic relationship, with its reliance on language for its practise, and on the symbolic use of language as its creative medium, was Jesse's apparent inability to use language in this way, and where the languaging between us was somehow a foreign currency which made it impossible for psychotherapy to occur, or for a psychotherapeutic relationship to develop.

For Symington (1986, p.188) symbols form as soon as an 'I' emerges, and it remains as a 'link containing both emotion and the personal'. The symbol has a cognitive component and is therefore the essential link between intellectual and emotional understanding. Man cannot live an autonomous life, or a life of meaning without symbols, and it is through the capacity to use symbols that the ability to go beyond 'immediate relations and primary objects' into the wider world of experience is possible. Symington (1986) asserts that 'people need to draw constantly from the reservoir of emotional life to make contact with a constantly changing world', and that this contact is made by the formation of symbols. 'Through symbols humanity imaginatively forges towards a beyond. Without this capacity we stay stuck, clinging to the immediate, like survivors to a raft' (Symington, 1986, p.188).

The following, rather lengthy transcript from session 25 clearly illustrates Jesse's complete lack of the capacity to 'forge imaginatively towards a beyond'.

**Patient:** I suppose in a way education in school is pretty well organised it's like an adventure.....um.....you're just finding out new things all

the time, and.....everything's being taught to you and it's all prearranged, if one wants to say it like that.....*(section omitted)*.....and then.....um.....I don't know.....its just different altogether. .....*(section omitted)*.....It's got you nowhere, you're still as useless as you were originally but now you <u>have</u> to take a different step in a direction and choose something to do and.....um.....nothing gets done for you anymore.....it's like - life doesn't carry on like that, it changes completely.....*(section omitted)* - the whole thing slows down, peters out in a sense. *(Section omitted)*.....The school helps one and then eventually you get going on your own and you're supposed to continue in the way that you've been brought up.....*(Section omitted)*.....but all that is not going anywhere.....I don't have that going-on ability of my own in a way.....*(section omitted)*.....*long pause*.....I suppose that's why I looked for God so long, now I was on my own and I had to find direction from God in a way.....as to what to do.....you know, what <u>best</u> to do, and stuff like that, and there was nothing there, so now it's up to me completely, as to..... you know, where does the future go, and um.....it's like I just don't have the means, I'm not capable in a way. One shouldn't depend on God.....to keep things going, you know.....to take over from teachers, and to take over from masters and everything like that..... and one is brought up that God rules everything.....and with all this dictatorship going on one wants to find out - what does this dictator want? - And then the dictator is not there - so who's dictator? It's nobody! So you're back on your own recognisance again.....and so it's a case of what do <u>I</u> want and I'm not too sure I want to..... um..... you know, I don't have a greed or thirst for money, I don't have that kind of drive. What I <u>do</u> have is a wish to be inventive, or a wish to be creative..... but creativity in itself one can't just wish for, it's got to be found in some way, or developed or something like that, and that's where I have a difficulty again.....and it's um.....it's just not the same.

To be human is not only to live with a mirror, but also to be capable of entering into the world of language and understanding its metaphorical dimension. This process is facilitated by the father or the paternal metaphor, and mental illness is a failure or a deficiency in this respect (De Waelhens,1978). This idea then couples with the idea of a loss or a failure of the metaphoric or symbolic dimension of words, where words are no longer signifiers or symbols with objectively and inter-subjectively shared meanings, but what Van Eecke calls an 'imaginary real' (De Waelhens,1978, p.11). In practical terms, the patient is not able to embrace a metaphorical meaning and substitutes the lost meaning for an imaginary real - his symptom (Lacan; W. ver Eecke; De Waelhens, 1978). Hallucinations then, according to this construction, are

the patient's 'false attempts to insert himself in the human world of meaning creation'.

One of the themes in Jesse's telepathic experiences was that he had 'sorted out his religious differences with his family.' This could represent an attempt to enter into the human relational world and, were it true, would have re-established if not God, then his mother as dictator. This, in turn, would have given him some sense of meaning and human connectedness. Perhaps then, his psychosis, (which occurred after he left home) was an attempt to re-establish what little contact Jesse did have with the human world ie., through his family. What eventuated, however, was that God, or Jesse's conflict with his mother about God came between them, so the rift between them too, became irreparable and Jesse remained isolated from perhaps the only human connectedness he had ever really known.

Bollas(1987, p.141) asserts that 'what is lacking is that originating subjectivity which informs our use of the symbolic', - that the person's extreme objectivity has limited the development of his capacity to symbolise to the extent of affecting the symbolization of the self. This thesis has been outlined and supported elsewhere in this paper eg., the normotic personality structure, and in the section on early historical and developmental issues.

Thus, during the time of our therapeutic encounter, Jesse was not out of contact with reality, but out of contact with the human world, the relational aspect of the human order - that which gives life its meaning, its colour, its dimensionality, its direction and, above all, its humanity.
I wonder, however, if Jesse had <u>ever</u>, fully entered into this symbolic or metaphoric, humanised dimension. Sadly, it appears not.

## 6.5 Therapeutic Ambivalence and Other Countertransference Issues

I would like to open this section with a discussion on an issue which by now is probably quite apparent to the reader, but which has not yet been raised, and that is the issue of therapeutic ambivalence - mine and also that of my patient - or the ambivalence that was constituted between us.
Without intending to sound too harsh on myself, or too damning in what can only be described as an extremely, and, indeed, at times excruciatingly difficult psychotherapy, as I look back through my notes and read through the sequences, my ambivalence in the therapy is clearly apparent.
While my ambivalence was mostly relatively managable and, sometimes

even entirely absent, it was also, at times, undeniable. It is especially noticeable in the latter sessions, where the issue of termination was brought up by either Jesse or myself in virtually every session.
If I suggested termination Jesse would decline, if he asked that we reduce sessions, I would recommend that we meet again. When my feelings of deadness in the sessions made me desperately want to end the therapy, he would come to the following session feeling more alive again - and on we danced, each leading the other in what felt like a desperate dance between life and death. (If this sounds too theatrical - so be it).

I will illustrate our 'choreography of ambivalence' by following the sequences from session 32 onwards in more detail.

In this session Jesse had spoken of us 'getting a lot of nowhere' and of the sessions being meaningless to him. My response to this in the next session took the form of an offer to terminate therapy which Jesse declined. Although I did not pick this up at the time, Jesse's transference anxiety was clear in the following session where, while the feeling was warmer, he told me of a "Dear John" letter he had received and how this had hurt him. He then asked that we reduce the number of psychotherapy sessions to once a week. I suggested that we reduce them to twice a week, to which Jesse agreed.
In the following session Jesse came alive a little, expressed concern about wasting my time and reiterated his deep feelings of hurt in response to the "Dear John" letter, adding that perhaps he never had got over that. Following that session he reported to me that he was feeling even more hopeless, and in the next session Jesse again spoke of psychotherapy as just a way of passing the time ie., meaningless; in the following session, when I responded by suggesting termination, he declined and used the full hour, bringing up new and highly relevant material, after which he suggested termination. I countered this by requesting two more 'meetings' (as he called them) and he responded by talking about my patience, and loving and caring. Jesse clearly framed what was happening between us by talking, later on in that session, about the clash of wills between him and his mother. I picked this up as a transference issue, but Jesse did not respond. He agreed to come for two more sessions but did not arrive for the next one. I went to fetch him. This was supposed to be our second last 'meeting', but during that session he said he would like to continue psychotherapy once a week. The following session turned out to be our final one as Jesse left the hospital.

Bollas (1987, p. 253) says that the patient needs to create in the transference the atmosphere that existed in his family, and that the

analyst has to be 'the mother's child, the father's child, and the parent to the enraged and destructive child who in fury refuses any parenting, even if it is good'. In this way, the patient can 'believe in his analysis and **know that the analyst has been where he has been and has survived and emerged intact** with his own sense of self, an evolution in the countertransference that will match the emergence of the analysand within the transference from his family madness'. It is thus a 'going mad together, followed by a mutual curing and a mutual establishment of a core self' which is of the essence in the analytic process.

Was my ambivalence a countertransference reaction which was constituted through projective activity as a recreation of the primary maternal relationship - and was it not my task then to endure and survive and come out intact from this ambivalent environment?

In retrospect, and in terms of the above formulation, it appears that most probably my primary role or function was that of the frustrated mother - unable to reach or communicate with her son. This conceptualisation seems to make some sense of my experience of Jesse's emotional inaccessibility, his ruthless objectivity, his rigid intellectualising and immovability, his unwillingness to accept the value of our work on faith alone, the absence of mirroring and symbolism and his seeming inability to engage with me in a therapeutic relationship, and where, after a while, any attempt to look at feelings, or at inner processes, or psychic life or experience did not seem to make any sense to me either. This type of endeavour seemed superfluous and inappropriate, although (to use Jesse's phrases) - I mostly felt I 'could go along with it', or remained willing to 'do what I could to be helpful', or 'did not want to fight it' - as he had felt able to do in psychotherapy with me as therapist in his mother's role, and also in the past with his mother's attempts to get him to be more 'normal'.

I was most probably, at times, the mother's child also - where I had to live through Jesse's experience of ambivalent mothering.
Perhaps this mutually created ambivalence was already the beginning of our 'going mad together', (Bollas,1987), but where the resolution was always already foreclosed through a kind of non-acceptance of Jesse in having therapeutic goals - and which made any possibility of a resolution - 'a mutual curing and a mutual establishment of a core self' abortive.

I believe the countertransference was syntonic, and that what was created between us was a reflection of Jesse's need for me to experience his early, and perhaps even his ongoing home environment, and to embody his despair which, at times, I surely did - and that it was this, rather than my

own neurotic inability to process the ambivalent environment that contributed towards my countertransference feelings in the therapy.

Or could it have been, mostly, that the time we had together was unreasonably limited? And, of course there was always the pressure to 'make him better', and quickly. I do believe that had the hospital environment been more supportive of what they finally termed 'my ridiculous experiment', (I later discovered), this might have helped to contain my ambivalence at least to some degree.

While writers such as Redfearn and Fordham, Searles and others describe the countertransference experience with psychotic patients as intense and difficult and involving anything from feelings of cold horror, murderousness, fear (through projective identification), dismay and sadness, indignation etc., and most certainly very chaotic states also, and they include those primitive 'therapist-impulses' such as wanting to hold, feed, caress, and other such primal responses (Redfearn, 1980), my countertransference responses to Jesse held very little of the intensity one would anticipate or imagine in working with a schizophrenic patient. Apart from one clear and very intense experience of projective identification, where I had clearly embodied Jesse's complete and utter hopelessness, and I felt an almost intolerable despair and desolation at a time when it appeared that Jesse had given up hope, the main feelings I had were of being ineffectual, inexperienced and rather useless as a psychotherapist, inappropriate in my interpretations, inept or incompetent in facilitating the therapeutic process and unable to communicate or interact with Jesse in a therapeutically meaningful way, in short - pathetic and stupid and insensitive, and generally lacking in the sort of qualities I deem necessary in a good psychotherapist. There were often accompanying feelings of futility, and sometimes fruitlessness and pessimism, and often too, I felt demanding and persecutory and as though I was expecting of Jesse more than he could manage - these being mostly through upholding therapeutic goals. I do not mean in the sense of 'doing things', or 'getting better', but rather in the sense of relating and communicating in a human way (which were perhaps the same thing ultimately).

Futher to the above countertransference issues, I often felt plagued by the idea that a more experienced psychotherapist could have helped Jesse - could perhaps have found some way to engage therapeutically with him; could perhaps have made better or more meaningful, or deeper interpretations; could perhaps have somehow worked with the dream or the two images he brought to the therapy; perhaps have been less

ambivalent; or perhaps just been more accepting of the reality of Jesse's illness. In retrospect, and having surveyed some of the theoretical understandings of this type of psychopathology, I feel less tormented. While it is possible that someone else could have helped Jesse better, there is no certainty either.

### 6.6 Therapeutic Optimism or Omnipotence?

Karon & VandenBos (p.144) say that 'if the therapist is nonthreatening, does not interfere with the symptoms or interpret, and is willing to wait long enough, transference needs will emerge and a therapeutic relationship can develop', and Eissler (in Bellak, 1958 p. 324) in fact advocates for the psychotherapist an attitude of, and a belief in his own omnipotence, and says that 'therapeutic failure must be unacceptable to him, and recovery highly important'. However, I am concernedly aware that there is an important distinction to be made between therapeutic optimism as a helpful attitude, and as one which pertains to a naive grandiosity.

The question I raise here is one concerning optimism as an indispensible cornerstone for the staying-power required in working with schizophrenia, as opposed to a untiring, tyrranical determination to succeed (perhaps against all odds), and where that same optimism can then become one of two things i) a licence to expect and even persecute/tyrranize/demand of the patient that he respond at some point, at least minimally, to the therapist's dedication, patience, tolerance and whatever else he invests; and ii) a kind of omnipotence or grandiosity, where the psychotherapist imagines, or hopes, that he actually *can* feed or nourish and animate, infuse with life, resuscitate, or otherwise revitalise his patient. According to Romanyshyn (1990), however, what really occurs, is that all the therapist's energy, life-blood and breath, strength and dedication is being poured into a void - into nothingness, into the endless sand and seascapes of the patient's psychic world, a no-man's land of desolation somewhere between life and death. He suggests that the therapist will hope out of his own anxiety or fear of deadness, and that the therapeutic moment occurs only once he is able to recognise the tragedy, accept the limits and the failure, and can 'let go'.

Stein (1984) makes a similar point in writing about the maieutic countertransference. In the maieutic stance the therapist has as a 'root metaphor' a birthing process, and as his task - to assist this creative process through empathic holding. He writes that there exists a danger in this attitude of empathic holding since the analyst may mistakenly project a creative process onto the patient. In so doing, he fails to realise that

the unconscious or psyche of the patient is not yet pregnant, and it is only once he removes the pressure for the patient to be creative and pregnant, that the possibility for such a pregnancy to occur (or not to occur) exists. The patient may then be what he truly is - even if that is 'conflicted and sterile' and can remain so for as long as he or she needs. A real person is then able to emerge and a true birth to occur in its own time. Clearly, therapeutic optimism, or omnipotence, in the sense that they are described above, would inhibit this process.

### 6.7 Was This a Waste, a Failed Psychotherapy?

Romanyshyn (1990) suggests addressing the question of therapeutic failure or waste from two perspectives ie., in the sense that psychotherapy is more than just for the patient. I have already explored, in some detail, the apparent lack of usefulness of psychotherapy for the patient, or his inability to use the therapeutic relationship, so the question then becomes, if my patient did not benefit from the therapy, how did I? What have I, as a training psychotherapist learned that I can take with me into my practise so as to better help other, future patients? - Or what did I perhaps learn about myself, for my own personal growth and development?

I think perhaps the most important thing I have learned is that there are limits to the usefulness of psychotherapy and, narcissistic or omnipotent needs notwithstanding, there are patients for whom no amount of holding - or letting go, loving and caring, tolerance of ambivalence and anxiety, patience, optimism, staying-power or tenacity, soul-searching or desire to help, maternal or paternal presence - makes any noticeable difference!

However, given the assumption that his relational presence is nonetheless <u>always</u> the place of healing, what is it possible for the psychotherapist to hope to achieve with a patient such as Jesse? Clearly, I was hoping for something different than what was achieved in the 4-1/2 month period I worked with Jesse. Yes, he was feeling better by the time he left than he had been 4-1/2 months earlier - enough so as to be able to function, even if only minimally, outside the hospital (albeit in a protected environment and on medication). I was grateful for, and truly delighted with that. I guess I was hoping, at the very least, to make some kind of real meaningful, therapeutic and/or human contact with Jesse who was so sadly lost to the world and relationships.
Was I altogether too ambitious? Maybe.
Romanyshyn (1990) suggests that there is always a lot of grace and luck that goes with this achievement.

In their paper on the treatment of chronic psychoses, Frey-Wehrlin, Bosnak, Langegger & Robinson (1978), address the issue of working with chronic patients, that is, once the assumption about the patient changes from an expectation that he will get well, to a realization that it is unlikely that anything is going to change in the future. They assert that this realization allows the therapist to accept the patient fully, and that this in itself, on occasion, can facilitate the recovery process. The implication is a change from 'the urge to heal' to an attitude of 'accompaniment'. The writers state that regardless of whether or not psychotherapy is the agent of change, what will always make psychotherapeutic work worthwhile is to remember that a spontaneous remission can sometimes occur, and that in such a case 'it will make a difference to the patient.....whether the duration of his illness- possibly many years of his life- figures as a great void or whether it was filled in by a stable human relationship and regular meaningful discussion'. Frey-Wehrlin et al. (1978) consider this to be the chief aim in working with chronic patients and they see their work as 'an empathic accompanying of the patient' rather than 'technical manipulation'.
Frey-Wehrlin et al. (1978) add that the chronic condition, while defying transformation, does not resist recognition, and say that it is in this encounter that a symbolic correspondance to the alchemical vessel is achieved. It is their thesis that the chronic condition is not easily surrendered - or perhaps never given up - as the fall 'over the edge' was a fall into Paradise. Therefore, any violent attempt to bring the patient back into life will be resisted. The authors say that a transformation can occur out of the therapist's 'guile and strength' and timing in acting on his syntonic countertransference (following Fordham's conceptualisation), and they also name luck as an important factor. However, they consider that the real work with chronic patients, is 'in waiting for the moment', (the unblocking of the chronic condition) -'even if it never comes'.

This formulation makes some sense of the value of my work with Jesse, for surely I did at least as much, and offered an empathic accompaniment, and in this regard the therapy cannot be considered a waste, (even though it is possible that the upholding of therapeutic goals at all, the degree of ambivalence in the therapy, and even my lack of experience may have sabotaged any real possibility of change). If perhaps there had been less pressure to succeed, and quickly, I might have been able to continue for longer and with less ambivalence, and perhaps without any therapeutic goals other than 'empathic accompaniment'.

Perhaps too, it was altogether unrealistic and even unreasonable to expect <u>any</u> measure of success within 4-1/2 months, and that what was perceived

as a therapeutic failure had less to do with either of us than was finally supposed.

Worth considering too, is that while Jesse was in psychotherapy he did not relapse even without medication which, unfortunately, once he was in the outside world, he did.

As I write these words I feel a great deal of warmth towards Jesse, and a deep sense of gratitude, for his having allowed me, another human being, to see into his lifeless world. Jesse showed me the depths of the void which was his existence with an honesty and courage I am not sure I have. Jesse also showed me a new level of acceptance - I think perhaps he accepted his condition long before, and with more grace, than I ever could or did. Jesse surely was the unusual person he said he was.

If it is as Frey-Wehrlin et al. (1978) say, ie., that empathic accompaniment really counts - then perhaps our encounter succeeded for Jesse too, and the therapy cannot be considered a waste for either of us.

## 6.8 What, if Any, Other Possibilities Might There Be for This Patient?

Romanyshyn (1990) suggests that while there would hardly be an institution, even amongst the most liberal-minded, willing to support such a venture, one way of dealing with a patient such as Jesse might be to take his symptoms literally, or at face value - to acknowledge his death to the world, his inability to relate with others in a truly human way, and his withdrawal from light and life. To do this, one would put him in a small, enclosed, safe place and leave him there without any treatment, or human contact, for as long as it takes him to do what he needs to do, and whatever that may be.

As I attend to my feelings on this idea, several responses emerge. The first is one that almost amounts to relief, since this formulation provides a true recognition of, and respect for the integrity in Jesse's symptoms - which is perhaps something that has not been shown them to any great degree, or in a way that he could appreciate, thusfar. His symptoms make it impossible for him to live in the world, and perhaps all we <u>can</u> do is to let him live 'out' of this world, or rather, live out his symptom. For me, there is a real honesty and true acknowledgement in this response to his 'speech of the suffering soul' (his psycho-patho-logy).

A second, and more considered response recognises the fact that it is

impossible to know what would happen. Two possibilities come to mind - the first being that Jesse may become acutely psychotic again, at which point it might be possible to work better with him, for example in the way that Perry, (1980) suggests; the second is that he might never again come out 'of the womb' or the 'coffin' or 'box' - or else he might take his symptom one step further and really die. But I truly feel that if that is his process, then it is inevitable that sooner or later, in one way or another, with or without acknowledgement, it will occur.

## CHAPTER 7

### 7.0 Some Conclusions

While I am loathe to doubt the integrity of writers such as Karon and VandenBos, it appears that their view is a somewhat optimistic one, and one that cannot be taken completely at face value, since it fails to expose the shadow side of schizophrenia, and that is chronicity - where no amount of psychotherapy, of whatever ilk, is going to make the patient better - and where ultimately, for some patients, psychotherapy may not be the treatment of choice.

Brooke (1990) made the point that if the shadow side of change is lack of change - the shadow side of the therapeutic endeavour must be chronicity. If individuation involves the integration of the shadow, then one of the goals of psychotherapy must surely be the acceptance of chronicity- and the therapist's task must then be to give and care without goals.

Thus, in having psychotherapeutic goals at all, there was a kind of non-acceptance of where Jesse actually was in space and time. Might this fact not have contributed to what appears to have been a therapeutic failure? Might not a more timely acceptance of chronicity have been propitious for Jesse - and in this way might we not have borne witness to the maieutic process rather than to its shadow?

It appears from this, that we must look at our goals in looking at chronics - in terms of management, practise and also in terms of ourselves as psychotherapists. Our work with chronics requires an important countertransference shift, but one which does not mean being lulled into a kind of resignation which might foreclose the maieutic 'birthing' process or prevent a spontaneous cure. Thus, Jesse is not only a person but also an image or a figure in the lives of most of our patients and of ourselves also. He has shown us that there exists a place of inaccessibility which must be taken on its own terms.

One has also to face the tragedy, the question of the point at which the patient is seen as chronic- and at which a shift in stance, or a realization or acceptance of chronicity can occur. This is a tragic question with which we have to learn to live, as there is no premature answer.

Whether or not psychotherapy with Jesse was ultimately a failure cannot ever, conclusively, be known. The extent to which my ambivalence sabotaged the therapy is also not answerable, and neither can the extent of

the effect of my relative inexperience be absolutely identified.

Finally, the long-unanswered question remains - what kinds of interventions, applied to what kinds of patients, by what kinds of therapists, under what kinds of conditions produce what kinds of changes? (Parloff, 1980). And until this is satisfactorily answered, our base of knowledge will continue to grow only through the efforts of our patient psychotherapists and our patient patients who continue to teach us.

As a postscript, Jesse left the hospital on medication and was fine for one month. Apparently there was some kind of administrative 'mixup' and his file was not transferred to Cape Town in time and he stopped taking his medication. Shortly after that he became psychotic again and was rehospitalised. It is now five months since I have seen Jesse and I am unaware of his current condition or his whereabouts.

Our dance together has ended, and I am richer for my encounter with Jesse.

I hope in some way, however small, that he is too.

## CHAPTER 8

## 8.0 BIBLIOGRAPHY/REFERENCES

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