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The Relationship Between Psychoanalysis and Schizophrenia

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In this article, the author considers psychoanalysts' current attitudes towards schizophrenia. After early optimism of a psychoanalytic approach, interest has waned, other than in the field of first-onset psychosis. This was because of poor outcome figures and regarding schizophrenia as now having a biological, rather than psychological, base. The author argues that there is a paradox, because only psycho analysis offers a framework for relating to psychotic patients in a way that helps them to make sense of their experiences. A framework is described, with clinical examples, to illustrate the application of analytic thinking to patients with schizophrenia. Psychoanalysis needs to revitalise its attitude to psychosis, as it has a significant contribution to make within general psychiatry, not least in the training of the next generation of psychiatrists.

Introduction

In a recent article entitled 'Psychoanalysis and schizophrenia: A cautionary tale' **(2001)**, Willick cites the history of psychoanalysis and schizophrenia as an example of psychoanalytic theories that have not stood the test of time.

Analysts have imposed their theoretical views of aetiology, attributing schizophrenia to early trauma linked with an emotionally unresponsive mother, rather than accepting an underlying biological causation. It was therefore not surprising that the outcome figures from Chestnut Lodge, where they had employed a purely analytic approach to schizophrenia, were unfavourable, in contrast to the results with more borderline states **(McGlashan, 1984)**.

In a review of British object-relations theorists, with the exception of Rosenfeld, Willick **(2001)** reported that he was unable to find a single well-documented case of schizophrenia in the work of Klein, Winnicott, Fairbairn, Gun trip and Bion. Without any clinical supportive evidence, they had all lumped together schizophrenia, schizoid personalities and other severe character disorders as examples of failures to adequately overcome the paranoid-schizoid position.

Bion, in fact, did see patients with schizophrenia analytically and, from his clinical experience, he developed a whole new way of approaching schizophrenia, as shown in the clinical illustrations I present below.

Willick does not express a view as to where that now leaves analysis in relation to schizophrenia, if it has a biological basis. Does psychoanalysis still have a useful contribution to make?

A review of the analytic attitude to schizophrenia is long overdue and carries important

consequences for the contribution of psychoanalysis to the field of general psychiatry (**Freeman, 1988**; **Jackson & Williams, 1994**).

One might list a whole range of controversial issues meriting further debate, for example, the question of acceptance or repudiation of the death instinct (**Black, 2001**;**Lucas, 2002**), and the existence or otherwise of transference in psychosis, with its implication for analytic technique **(Rosenfeld, 1969)**. Also does one make a clear distinction in one's mind between borderline states and schizophrenia, both in terms of psychopathology and prognosis **(Rey, 1994)**?

However, the biggest question to be confronted when approaching schizophrenia is the aspiration to cure. After all, we refer to analysis as 'the talking cure'.

Current research concentrates on attempts to **prevent the development** of schizophrenia through vigorous treatment of **first-onset** psychosis. Optimistic reports have been published in relation to both a combination of C.B.T. and family therapy and an analytically based approach (**McGorry, 2000**; **Jackson, 2001**). Time will tell whether this optimism proves to be well founded.

Many analysts hold the view that, once patients have established schizophrenia, they come into the domain of '**no hopers'**. These are cases we cannot cure, cases who remain resistive to offered therapeutic measures, cases with recurrent episodes of disturbed behaviour and cases demanding of long-term care.

In analytic terms, these are hardly rewarding candidates for treatment, especially if there proves to be an underlying organic rather than psychological substrate.

However, a **paradox** remains. Speaking as a practising psychoanalyst, who also works in the field of general psychiatry in a busy, socially deprived area of North London, I have found that ***only*** **applied psychoanalytic knowledge** and technique provide the tools to gain **understanding** and talk **meaningfully** to these patients about the working of their minds and their emotional experiences. Psychoanalytic thinking provides the framework to help the individual, their relatives and the professional staff in making sense of, and living with, the condition of schizophrenia.

Psychoanalysis needs to **rethink its way** in relation to schizophrenia. At one point there was much interest in an analytic approach, both in the US and in the UK, related to emerging Kleinian theory. With the initial optimism not resulting in cures, enthusiasm has waned and the special interest units in the UK, at Shenley and the Maudsley Hospitals, preceded Chestnut Lodge in their closure.

Psychoanalysis can be viewed in three ways. First, it is an accumulated body of knowledge of the working of the mind, especially focusing on the unconscious origins to emotional drives. Second, it is a method of treatment of mental disorders through utilisation of the transference and countertransference. Third, it is a research tool, through individual cases seen analytically, four to five times a week. Detailed case studies of disturbed patients continue to contribute to our overall knowledge of how the mind operates in psychosis (**Sohn, 1997**; **Lucas, 1998**). However, here I am referring to an under-appreciated area: the importance of the applied use of analytic insights in thinking about problems and sharing thoughts with staff, patients and their relatives in everyday psychiatric practice.

There is a neuronal network, a biochemical pathway and a psychological level underlying the expression of emotional drives **(Rey, 1994)**. Approaching problems at one level does not contradict a simultaneous approach at another level. In other words, administration of medication and talking to patients with psychotic disorders are not contradictory, provided one has sorted out the reason for one's actions in one's mind and can explain the reason to the patient. In the case vignettes presented below, **all the patients** were receiving **anti-psychotic medication** with the aim of helping to calm them down. However, this did not prevent analytic

understandings of the patient's behaviour, in each case, being of **crucial importance** to their management.

The time has come to revitalise an analytic approach to schizophrenia, applied in a realistic way, in the relevant setting, i.e. within general psychiatry. To do this successfully, one must develop a robust and coherent **framework**. I will end this short review article by outlining some aspects to this framework that I have developed in over twenty-five years of working in this area.

Developing a framework

The basic philosophy

When we grow up, we all have to live with ourselves and our own psychopathology and 'make the best of a bad job' in life. Some have to live with more severe psychopathology that might at times completely dominate, adversely affecting the individual and his/her family. Learning about these experiences and how best to cope with them can be a lifelong process.

A patient on admission angrily said, '**I am God's older brother'**. I replied that he must really be fed up with his younger brother getting all the publicity! The patient stopped, smiled and a mutual warmth developed between us from that time onwards. Previously, he had taken his brother's car and driven it into a wall, fortunately without any resulting serious injury. He thought he was omnipotent; that, at the time, he could do anything. My point is the need to relate meaningfully to our patients to start an ongoing, shared lifelong experience, even if at times the rapport may be temporarily overwhelmed, like a tidal wave, by the psychosis. **Bion** referred to this as the never decided conflict between the life and death instinct in schizophrenia **(1957)**.

Tuning into the psychotic wavelength

Bion produced a grid, which invited us to question, whenever we are dealing with a patient with a major psychiatric disorder, whether we are receiving a communication from a non-psychotic part or a psychotic part masquerading as normal **(Bion, 1957)**. After all, the **commonest symptoms** of schizophrenia are not auditory hallucinations or paranoid delusions, encountered in some 60 per cent of cases, but **denial and rationalisation**, found in over 95 per cent of cases **(Lucas, 1993)**. The following are everyday examples.

a/ A patient was admitted having **smashed up his place**, in a psychotic state. When I saw him on the ward the next day, he was quite calm. He denied having any mental problems. His only problem was that he didn't know if I was Dr Lucas or an impostor. He thought of ringing the police about this. His awareness of his disturbance was projected on to me, so *I* was the impostor rather than himself, as if he was not the same person who only the previous night had smashed up his flat.

b/ A more serious case was of a man, who, in a state of psychotic relapse, had **thrown bleach** in the face of a stranger: a young woman. He had wanted to project his problems into her and scar her. His mother had contacted the professionals, as she was concerned that he was relapsing. However, when seen the day before the incident, he had managed to convince the approved social worker that he was all right and that it was his mother who was the problem.

The above case illustrates how the capacity to be aware of **denial and rationalisation** is of crucial importance in risk assessment.

Differentiation of the psychotic from non-psychotic personality

In addressing patients with schizophrenia, as Bion pointed out, we always need to think in terms of **two separate parts**, the psychotic and non-psychotic, **not one person** (**Bion, 1957**; **Lucas, 1992**).

The psychotic part is intolerant of frustration and attacks thinking arrived at by the work of the non-psychotic part. The following case serves as an illustration.

c/A **young woman** was admitted to our mental hospital in a thought-disordered state. While on the ward, for months she kept **denying** having any problems. One weekend, she went home to her mother and jumped out of her bedroom window, fracturing her leg. While still on the orthopaedic ward, she came to see me in my out-patient clinic. She was in a frightened state and asked to be readmitted to the mental hospital, on medical discharge.

When she returned to the mental hospital, she reverted to a **denial** of any problems. Anti-psychotic medication was having no effect on her mental state. //I then realised that she hadn't **jumped** out of the window in a state of adolescent despair, she had been pushed out by an **intolerant part**.

When I put this to her, her mental state suddenly changed. She made out that she was religious and that I was bigoted and intolerant towards religion. She also began to speak for the first time in ward groups, saying that patients should be given holidays. However, at least the murderous part was now in the open for us—and her mother—to appreciate. It also explained why another part of her, the non-psychotic part, was in a frightened state when coming to see me, asking for readmission, as she felt on the end of a murderous attack.

Ideographs, hallucinations and delusions

The **aim of the psychotic part** of the mind is to **relieve itself** of emotional pain through projection. If a painful feeling arises, it will evacuate it to produce an **hallucination**. If the sensation is projected into an object, it becomes a **delusion**. The characteristic of the object's behaviour will be determined by the nature of the hallucination, for example, a television may be experienced as spying or talking depending on whether the projected hallucination was visual or auditory in origin **(Bion, 1958)**.

According to Bion, the psychotic part has **attacked** and **fragmented** all parts of its mind to do with registration and differentiation of internal and external reality. The psychotic part stores past events, which Bion termed **ideographs**, for later use for the purposes of either emotional evacuation or communication. I think of these past events stored in the mind like mugs on pegs, to be taken down and used when needed. The challenge to decipher ideographs brings interest into general psychiatry, into what otherwise threatens to remain just very demanding and soul-destroying work, leading to premature retirement.

d/The following case serves as an illustration of **deciphering an ideograph**. A **young man**, of Asian background, came into hospital saying that he was **Prince Edward**, son of Henry the Eighth! He

had no associations to his belief. The next day, he was behaving in a grandiose manner demanding cigars from the nursing staff. In frustration at his lack of associations, I said that he couldn't have a cigar as they didn't come into the country until brought by Walter Raleigh when his sister Elizabeth was on the throne. The humour was completely lost on him.

Later, at a ward review, we learned from a social worker how there had been an **arranged marriage** to a young woman who had come from abroad. He had beaten her up and she was now in a women's refuge. She didn't want to leave him for fear of deportation. We could now understand the ideograph. It was an attempt, by the psychotic part, to disown awareness arrived at by the work of the non-psychotic part through use of the ideograph.

Henry the Eighth made up his own religion and was not to be contradicted in the way he treated his wives. Our awareness of its meaning, at least, opened up the potential for relating to the patient about his behaviour.

The countertransference

If dreams are the royal road to the unconscious in neurosis, then the **countertransference** is the '*via regia*' to understanding in psychosis **(Rosenfeld, 1992)**. When patients in psychotic states disown troublesome feelings into others, this is an unconscious process, not immediately understandable to the patient or recipient. However, the countertransference experience may be crucial in trying to make sense of an overall situation **(Garelick & Lucas, 1996)**.

e/ At a psychosis workshop, a junior doctor presented a problem of a patient who had developed a delusional belief that he would be **cured if the doctor sneezed**. As a result, the doctor became very careful not to sneeze in a session, fearing that it would have a catastrophic effect. The patient seemed to centre all hopes of a quick cure on the doctor's sneeze!

The **doctor feared** that, if he sneezed, he might lose his patient as a potentially responsive person, through giving him a magical cure. The fear was that the patient would remain forever in a manic unthinking state and that he would have been responsible for producing it.

Understanding his countertransference fear of sneezing led to the doctor being freed to think and address the patient, namely, on the conflict of his aim of being in an isolated **omnipotent identification** versus being with others as supportive human beings.

The exoskeleton

Patients with chronic psychoses need, above all else, provision of an exoskeleton, a **supportive environment** that can **think** and **care** for them. This dynamic often goes unappreciated when planning the needs of patients with the closure of the asylums. Certainly, the quality of care and expertise developed at Chestnut Lodge seems to have been forgotten, when everything is reduced to mere outcome figures **(Silver, 1997)**.

Finally, mention should be made of the function of the currently overburdened acute psychiatric ward, as both container and safety net if a patient relapses. Since psychotic patients tend to fragment and project, it is important for all carers, professionals and relatives to gather together to see who might have the vital piece of the jigsaw to appreciate the whole picture. For example, it was the social worker who brought the vital piece of information to understand the patient's delusion of being the son of Henry the Eighth.

While medication may prove essential in calming down and controlling an excitable psychotic state, it is the analytic framework that helps to provide the container to make overall sense of the presenting situation in a needs-adapted way **(Alanen, 1997)**.

The challenge for the future

In the UK, junior doctors start psychiatry with no real knowledge of psychoanalysis. With schizophrenia, they are only taught to look for first-rank symptoms when performing a mental-state examination. If you provide informal clinical seminars for them, things start to happen!

f/ A junior doctor described how a patient, in her first psychotic breakdown, made an **outline with her hands of the junior doctor** as he was leaving the room. She then gathered up the outline in her hands and put her hands on her head. For the next three months, she walked around with both hands on her head.

Clearly, she had created some **idealised phantasy** figure of the junior doctor and put it into her head. While words such as projective identification, at this stage, have no meaning to the junior

doctors, such cases light an interest in an analytic approach. The doctors may start to realise that analytic thinking is anything but passé when trying to make sense of the working of the mind in schizophrenia. Our challenge is to excite the minds of the junior doctors.

Despite Willick's cautionary tale, the analytic contribution to schizophrenia is anything but

redundant. The requirement now for psychoanalysis is to gather together like-minded interested parties from the UK, Scandinavia, the US, South America and elsewhere through the aegis of the IPA.

Analytic thinking may yet have its greatest impact for the general public in what may appear to be the most unrewarding of terrain: the world of established psychoses.

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