moment in time the SHO needs a meaningful framework to orientate him and enable him to find a way of talking to the patient about the battle of the two parts, and help the staff to support the dominated tearful part that wants to live and train as a teacher, but is currently being held in a suppressed state. Only once this has been spelled out to the patient can periods of non-naso-gastric feeding be tried out in the context of an attempted mental dialogue, even if for long spells all sanity remains projected into the staff and the anorexic behaviour remains predominant.

In all psychotic disorders, staff may have to endure stages of seemingly never-ending intransigence, such as those that occur with protracted episodes of depression in hospitalised cases, where it is necessary to wait for the episode to relent. During these periods, it is important to keep a live dialogue going, even if at times it feels as though this is confined solely to the staff and carers.

The clinical situations encountered in general psychiatry may sometimes feel as though they have little relevance to the world of an everyday analytic psychotherapy practice, although they can help one to feel for analysands who may have had to cope with living with a parent with a major psychotic disorder in their childhood. However, if the analytic concepts introduced are pertinent to the presenting problem, they can be extremely helpful for the SHOs.

For a time, the SHOs are freed from the restrictions of purely phenomenological thinking and enabled to take an interest in their own responsiveness to the material. Through the introduction of the analytic framework, they are provided with the means to begin to develop confidence in speaking to their patients, and to move the relationship from a monologue to a dialogue, even if at first this takes place only in their minds. It is hoped that those SHOs most receptive to these ideas, and I have found this already to be the case in practice, will form the basis for the next generation of medically trained psychoanalysts, fulfilling Freud's wish that a psychoanalytic presence remains in the field of general psychiatry.

A specialist registrar's experience of being with a patient with schizophrenia

I am grateful to Dr Sally Davies for permission and encouragement to use the following material for educational purposes.

The patient was a young man aged 27 with a diagnosis of schizophrenia. He was seeing a consultant general psychiatrist in his outpatient clinic and was on conventional antipsychotic medication. He had taken illicit drugs in the past, but not recently. He had expressed a wish for individual help and was referred by the consultant to the psychotherapy department for this.

The following material includes a précis from three sessions illustrating the experience of direct contact with the mind of someone functioning in a predominantly psychotic way. He was being seen weekly. The specialist registrar, understandably, had great difficulty in following and recording the gist of the sessions, but they are presented as experienced.

First session

The patient came in full of paranoid thoughts. He said, 'They know what he is thinking'. 'They look at him'. He stares at someone, and it is someone to check out feelings by the way he reads their response. He cannot masturbate at home. Perhaps this is why he has a homosexual relationship – mindless – with a friend. Then he feels ashamed of this, and becomes concerned over his mother's attitude and her disapproval of this behaviour. The therapist says so she, the mother, becomes the concerned one. The patient says that he brightens up when he plays tennis.

Second session (two weeks later)

He misses the next week's session. He had a charity gig last week and completely forgot about the session that he had missed. Mother was away in Devon. They (he and his sister) found that they had run out of money and had no food. So they decided to have a party (as if this would be a way to get food).

As well as having problems with girls (meaning coping with the way they looked at him), he related another problem. He was picked for jury service. He was the foreman in a rape case. He was told not to discuss the facts of the case outside. He found it very difficult not to do this. There was not enough evidence to convict the person. He was worried that he was influencing other members of the jury. What if he was guilty? He was worried that other members of the family of the rape victim would find him and beat him up.

He had written a song called 'Sex Offenders'. People liked his song. A long time after playing it in gigs, a girl made a comment, which he took to indicate that she knew that he had written the song and he wondered how she knew this. He was worried over sexual feelings. A man had given him a massage. He said to the receptionist, 'Maybe you are a paedophile?' The receptionist said that it was him who was the paedophile (he had recounted this story before).

Third session (a week later)

He had not slept very well. He worries that if he doesn't sleep and it continues, it means that he is becoming very unwell. It preceded breakdowns. Then he slept OK so it was all right. He said that the session last week had been very useful as he had spoken about the jury service.

He is working with a friend in the recording studio. He didn't sleep, then the friend didn't sleep (as if it was then the friend's turn not to sleep). He gets very emotional over music and can reach people (with it).

He says that there is a small room in the house where he sits with his mother and they don't use it very much. It is worse since the abortion of a girlfriend, also with cocaine. He gave up everything to be a musician, gave up normal jobs.

He feels responsible as a musician and has to keep doing it. He doesn't stop this when ill; there is a feeling with it that he can do anything.

There was some sadness around and the therapist said that the patient was sad that he still couldn't do everything.

He then talked of the effect of cutting his hair. He feels more free if it is longer and then creative. With medication, his hair is thinner, so he cuts it and feels like a schoolboy.

The specialist registrar noted in her mind that father was very distant compared to mother, and linked this with the patient's thought about mother's anger about the sex with the boyfriend, but she did not say this to the patient.

The specialist registrar's countertransference reactions

The doctor felt that she had to act as the patient's ego function, without frightening him by doing this, but she felt that she should be realistic in her advice and response. She also had a fear of becoming an

ideal object for him, with him becoming dependent on her for answers, as if she would be responsible for creating this unhelpful dependent problem for him. She felt that with borderline patients there was a theoretical framework for diagnosis and approach, but not with psychosis. She felt it was a different experience, but one which all senior doctors should have as part of their training.

Discussion points

The doctor raises the question of whether there is a theoretical framework of approach to psychosis that differs from the approach with borderline states. Bion would say that there are two separate parts of the personality, the psychotic and non-psychotic and, in schizophrenia, one always has to deal with the problem presented by the psychotic part first.

A basic problem and one that led the patient to seek therapy is that the psychotic part needs someone to think for him, as he is incapable of doing this. However, since he attacks any separate person because they represent a threat to an omnipotent state, he gets into dreadfully confused states with his objects.

We can follow this theme in the material presented above. If he projects out into people, they immediately know his feelings and this is a disturbing experience. He has no container for his masturbatory phantasies, i.e. no container breast/mother. This contributes to the countertransference feeling that, unlike the situation with borderline patients, where the primary complaint by the patient is lack of understanding containment from mother and a premature ejection into the real world, here there is felt to be no containing framework whatsoever.

The patient is aware that his view of mother's reaction to the homosexual relationship is linked to his attack on the mother or maternal breast. He doesn't really feel that he has an established adult homosexual orientation, and sees the homosexual relationship as mindless, the aim being to obliterate difference. He feels that the mother linked to an adult mind and sanity would not approve of this behaviour.

The need for some firm intervention, which is not occurring, may account for the therapist's thought about the patient's distant father. The patient brightens up by physically distancing himself from his

conflicting feelings about the nature of his homosexual behaviour, by playing tennis. He then misses a session.

He then gets caught up in the excited mood of the charity gig, his own idealisation of his music (idealised masturbatory triumph over his conflicts) and he completely forgets the next session. The therapist is felt to have gone away, like his mother who is on holiday in Devon. He has turned the situation around so that it is the therapist that has left him rather than the other way round, with him missing the session.

He then runs into trouble, with no food being provided by the therapist mother, so resorts to manic states with idealisation and attacks on awareness. This is manifest in the material about influencing others' minds, the rape case and his idea of persuading the jury that the accused is not guilty, idealising his song on 'sex offenders', and worry that others will see through his behaviour and see his sexualised excited destructiveness, in the reference to the paedophile.

In the final session there seems to be an attempt to put his critical thoughts to sleep by becoming more manically excited over the power of his music, which gives him power over all others and enables him to become the universal provider, triumphing over the mother therapist. By projection of disturbing insight into others he distances himself from awareness and reduces the risk of a more extreme manic breakdown leading to hospitalisation.

The attack on the container is returned to in the reference to the abortion, use of cocaine, and his renunciation of life to be the omnipotent musician, leading to his comment on the very little used small shared room for him and the mother/therapist.

The therapist is subjected to the experience of a non-stop monologue, with very little room for the development of any shared reflection on the functioning of the patient's mind.

The patient's wish to actualise a state of total omnipotence where he could help everyone through his music was linked to his masturbatory phantasy that he could renounce the real world in which he needed a relationship in order to develop his thinking. The therapist articulated his sadness over his failure to achieve this. Perhaps taking on his feelings and becoming like a friend sharing his musical recording made him feel better because he had found someone to take his projections. This is suggested by his comment that he felt better after he recounted the jury service story to the therapist.

However, the wish to achieve some magical ideal state either by being the ideal provider, or alternatively by the therapist assuming this

role, leads to the therapist's countertransference concern that she has allowed herself to be treated as an ideal and that this was not helpful for the patient.

Rey (1994a) described what he termed the claustrophobic-agoraphobic dilemma as a dominating feature in schizophrenia. The patient wants to distance himself in order to be free from awareness. He does this by projecting into the therapist and then missing the next session. However, he then finds himself without a needed mother/therapist so he returns to his sessions and the cycle of distancing through projection repeats itself.

The therapist, who has allowed herself to be open to receiving the patient's powerful projections, is left trying to process her feelings. The non-psychotic part of the patient's mind feels frightened of being taken over by the manic state of mind, while the manic state of mind does not take kindly to being scrutinised. So the feeling that the therapist is left with is that she needs to act as an ego function, to do the thinking for the patient, but without frightening him by exposing him to the full awareness of his state of mind.

One can appreciate that the issues to be considered here are very different from those in the case of a non-psychotic patient. For a specialist registrar an experience like this may help them to develop a deeper feel for the way that the mind works in psychosis. They will then be able to use the experience gained in other encounters within general psychiatry.

A common feeling that results from involvement with a patient in a psychotic state is of being left with a headache if one doesn't impose some rationality on the material. This is a reaction to the wish of the psychotic part of the patient to attack thinking and the therapist's mind. The case material illustrates this.

It is always easier to be in the role of the supervisor. The therapist brings the couple, the patient and themselves, to supervision. In supervision one has the opportunity to make slow action replays, as I have done here, to try to make sense of material that is produced with bewildering speed in the sessions. The trainee needs the opportunity to work with an experienced supervisor in order to enable them gradually to develop a framework of approach to the patient and begin to gain the confidence to make potent interpretations.

In an ideal world all specialist registrars would have the opportunity to gain one-to-one clinical experience with a psychotic patient. A period of personal therapy also helps enormously in gaining

confidence in relating to the inner world, and is to be encouraged in all trainees who seek to learn to do this, not merely in those who wish to pursue formal analytic psychotherapy training.

Referral of patients with schizophrenia: identifying the role for the psychotherapist

Introduction

I am grateful to Marcus Evans for his permission to use this clinical material, shared in a supervisory setting. He presents from the position of an experienced analytic psychotherapist, involved in relational work between an NHS psychotherapy clinic and local psychiatric services (Evans 2006). He often found that his view of the patient's needs differed significantly from that of the referring psychiatric team.

Background history

The patient was a 30-year-old man referred with a diagnosis of paranoid schizophrenia, although this was now disputed by his team. He had been seen in weekly psychotherapy for six months. Mr Evans took him on the condition that he continued to be seen by a psychiatric team for ongoing medication and psychiatric care.

The patient's parents separated when he was 3 years old. He was angry with his father because he did not take any interest in his upbringing, and angry with his mother because she remarried when he was 15 years old and no longer gave him her undivided attention. He successfully completed several O Level exams, but then started smoking 'skunk' (a strong form of marijuana) with a group of school friends and dropped out of the sixth form. The patient became obsessed with stalking his mother, and this resulted in her taking out a restraining order, for him not to visit.

When he was first admitted to hospital, the patient said that he was gathering evidence that he was the son of God. He expressed a belief that he would die when he reached 33, the age that Christ died. When the patient was put on antipsychotic medication, his mental state improved quite quickly. He then asked for someone to talk with and was referred for psychotherapy.

A week prior to the first of the sessions described below, the patient had