

“DON’T STEP ON TONY!” *THE IMPORTANCE OF SYMPTOMS WHEN WORKING WITH PSYCHOSIS*

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This article claims that the attention to a patient’s symptoms is critical when working with psychotic states. It asserts that viewing symptoms as a crucial inroad into the understanding of the patient’s issues is often disregarded in today’s mental health environment, which focuses almost exclusively on the elimination of symptoms with medication. The authors regard symptoms as presenting a vital inroad into the working relationship with persons suffering psychosis. A detailed case illustration is presented to demonstrate the way working with symptoms gives credibility to the patient’s reality and aids in creating a working alliance and in moving the treatment forward.

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Mrs. G was admitted to the hospital 2 hr before meeting our second author (M). He had already heard how upset she had made three nurses whom he knew to be quite mature and professional. What had aroused staff in such a rapid fashion was the intensity of Mrs. G’s responses to what they deemed to be appropriate requests. She shouted at them, calling them murderers and demanding they get out of her room before they hurt her children. So it was with some trepidation that M knocked on her door. After several knocks without any response, he gently cracked open the door and entered her hospital room. Mrs. G instantly began screaming at M, accusing him of almost killing “Tony.”

Today, many mental health professionals would approach Mrs. G with certainty that her behavior, with its florid visual hallucinations and, as it turned out, systematized delusional system, would warrant further questioning to determine whether she manifests enough symptoms to qualify for a diagnosis of schizophrenia. All of this would be in the service of a treatment plan most probably necessitating hospitalization or antipsychotic medication to control and eradicate her symptoms. This approach is referred to as the medical (or deficiency) model, originating in Kraepelin’s (1883) psychiatric classification

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system that considers symptoms as manifestations of a disease (London, 1973; Tasman, 2002). The goal is to reduce or eliminate the symptoms as quickly as possible.

We believe that symptoms, whether neurotic or psychotic, contain meaning and offer a window into a person's struggles as well as their efforts at adaptation and meaning-making. This is not a novel idea. Freud (1953, 1958) pioneered the notion that symptoms, like dreams, possess meaning and are attempts at adaptation. We are writing this article to revisit the notion of the significance of working with and being guided by symptoms rather than endeavoring to eliminate them. We argue that by quickly eliminating symptoms, a crucial opportunity to understanding of the patient's problems is disregarded and, perhaps more importantly, a vital opening into the working relationship with such a person is lost.

Despite Freud's (1958) emphasis on the significance of meaning in psychotic symptoms, he nonetheless believed that psychotic individuals are not suitable for psychoanalysis, because they do not develop transference. Freud's stand on psychoanalytic psychotherapy with psychosis did not prevent many psychoanalysts (e.g., Arieti, 1974; Benedetti, 1987; Bion, 1967; Eigen, 1986; Fromm-Reichmann, 1960; Karon & VandenBos, 1981; Lucas, 2009; Podvoll, 2003; Searles, 1965; Sullivan, 1962; Will, 1968) to advance our knowledge of the treatment of psychosis. However, in the current era of managed care and psychopharmacology, psychodynamic treatment of psychosis is unfortunately rare and often deemed inappropriate. For example, Michels (2003) has stated outright that "schizophrenia is a relative contra-indication to psychoanalytic treatment (p. 11)." Opposing this view is Bollas (2013), who recently published a book arguing that psychoanalysis is the treatment of choice for psychosis. He writes: "when the person is at their most vulnerable—and especially in breakdown—they are usually particularly amenable to help, and to the development of insight into the self (p. 7)."

Like Bollas, we are two professionals who have successfully worked with psychotic patients over a number of decades, resisting the popular trends in psychiatry and psychopharmacology that have pushed psychoanalysis away from the treatment of psychosis (Ophir, 2013). Psychoanalysts have also removed themselves from this work, the consequence of which is that when psychosis abruptly enters the treatment situation, analysts are ill-prepared to work with it, resulting all too often in a shift of focus to "managing" symptoms rather than exploring them. For example, a patient may develop a psychotic transference toward the analyst—"I know you love me. I'm going home with you." The analyst may, in response, quickly have the patient medicated or show the patient a photograph of his wife rather than continue in the reflective operational mode—"What do you think it means that there's nothing I can say to you that would convince you otherwise?"

In this article, we would like to focus on one aspect of the treatment that we deem to be of critical importance: working with psychotic symptoms. There are several reasons to begin with the significance of symptoms in therapeutic work with psychosis. Among these is the contemporary psychiatric aim to identify symptoms (using the *Diagnostic and Statistical Manual*, DSM) in order to diagnose and develop a treatment plan, which, more often than not, aims to eliminate these very symptoms with the hope of improving the well-being of the patient. One could argue that the cognitive behavioral therapy (CBT) approach, which is recently gaining popularity in the treatment of psychosis, has similar aims—that is, the elimination of symptoms (Garrett & Turkington, 2011; Herz, 2012; Kimhy et al., 2013; Turkington, Wright, & Tai, 2013).

Furthermore, because it is well known that the majority of patients stop taking their medications (Fenton, Blyler, & Heinssen, 1997; Kamali et al., 2001; Morken, Widen, &

Grawe, 2008), we argue that rather than rush to eliminate symptoms, one might try to understand and work with these symptoms. In so doing, we have seen that the symptoms frequently subside in their own time. In our view, psychotic symptoms frequently represent an adaptive response to an unbearable situation that holds the key to its creative resolution (Knafo, 2012). Recently, there has been an increased appreciation of the traumatic origins of psychosis (Fuller, 2012; Read, Mosher, & Bentall, 2004), leaving individuals with emotions that are often difficult to bear and to bear witness to. By appreciating the adaptive function of symptoms, they are recognized as (often desperate) forms of survival and caretaking. Therefore, by eliminating symptoms, one removes the meaning the patient is making of his or her situation, a situation that can cause rather than prevent breakdown (Bollas, 2013). Instead, treating symptoms with respect and curiosity conveys to the patient that he or she has the capacity to create meaning and to be an important contributor to the treatment. Working with psychotic symptoms is therefore regarded as a method for forming a therapeutic alliance.

For example, Carol, a patient of Danielle Knafo (DK), became enamored with her boss. When she confessed her love to him, he did not reciprocate and even told her he was involved with someone else. Carol became psychotic and developed erotomania toward her boss and a delusional system to deny the obvious. She wrote him letters and believed he was sending her signs of his love in a number of indirect ways. Every period and comma in the e-mails she received from friends and colleagues held the secret meaning that her boss loved her. She was unable to sleep and her agitation and hypervigilance grew. In treatment, Carol was medicated just enough to allow her to calm down and sleep in order to engage in the necessary reflective work of analysis. Little by little, she replaced her claim that “my mind broke” with another—“my heart was broken.” Her delusional system was understood as her manner of adapting to a reality (her boss did not love her) that was too painful to bear. Much of the therapeutic work centered on mourning a love that never was.

We regard the psychotic symptom as the *way in* rather than the way out. By taking symptoms seriously, we facilitate the creation of rapport with the patient because we are inviting the patient to be a credible informant of his or her own condition and, thus, a partner and collaborator in the treatment. If one eschews symptoms—the only clue the patient offers regarding what ails him or her—then we are left with an unequal relationship in which the therapist has no choice but to play “doctor,” defining what is wrong with the patient and taking full responsibility for the way in which to fix that wrong. Also, by artificially eliminating symptoms, one takes the risk of “sealing over” the problems rather than “integrating” them in a healthier manner (McGlashan, Levy, & Carpenter, 1975).

The presence of psychotic symptoms can initiate several treatment choices: (a) hospitalization, (b) medication, and/or (c) exploration. Clearly, the choice may involve more than one option. Just because one makes the decision to have a patient hospitalized or medicated doesn’t mean one ceases exploration before, during, and after such a decision. There are some clear contraindications to taking on a psychotic patient for outpatient therapy. These include danger and unreliability (which would translate into the inability to show up and pay for sessions). We do not believe that the presence of hallucinations or suicidality is contraindicatory in and of itself but, rather, that process is of greater importance than content. How does the patient speak of his suicidal thoughts? How does he experience his delusions? Is he curious about them? Has he developed strategies to combat them? If the patient engages in a dialogue with himself and with the

therapist about his symptoms, then there exists a positive potential to engage in outpatient psychodynamic work.

It is less stigmatizing to undergo outpatient therapy than it is with inpatient hospitalization. In addition, it is easier to maintain optimal functioning on an outpatient level. Hospitals are known to control every detail of patients' lives, thus removing their autonomy and freedom. One patient, when asked why he behaved in a very regressive manner while in the hospital replied, "I did it because I could." Remaining an outpatient, by contrast, appeals to the highest level of functioning, which has many benefits. A person can continue to work, see his therapist, live in his home environment—all of which offer stability, continuity, a sense of competence, and self-esteem. Living and functioning in multiple contexts approximates life in the real world better than an inpatient ward does. Therefore, one is not faced with transitioning from one environment to another. Not being supervised at all times invites the patient to "pull it together" and function until his next appointment. Once he sees he can do so, he is encouraged by his own ability, and this becomes self-reinforcing.

John confessed that he saw (hallucinated) dozens of rats outside DK's office building and that it took him an hour before he perceived (hallucinated) a path allowing him to run to the entrance. This happened every day, four times a week, for years and clearly reflects John's sense of imminent danger that accompanied his analysis. However, John's behavior also demonstrates his strong motivation to overcome even the most extreme fear in order to engage in therapy. His ultimate success (he never missed or was late for an appointment) reinforced his commitment to treatment and his inner resources in overcoming his fear and anxiety. This kind of "test" would not be possible in an inpatient setting, where surmounting such a conflict on one's own would not necessarily be encouraged and such hallucinations would be interpreted as a need for medication. After several years, when John developed a sense of safety within himself and in the treatment, the rats disappeared.

Safety of patient and therapist are critical determinants of whether and how to conduct outpatient therapy with psychotic individuals. Several variables tend to make people feel unsafe: unpredictability, unfamiliarity, intensity, impingement, silence, and speed (rushing). Space, too, can create a sense of lack of safety. Eli, a rather regressed patient once asked DK if he could move his chair nearer to hers. She agreed and he did so, but, as soon as he did, he anxiously began associating to frightening images of cannibalism. DK quickly stepped in by saying, "I forgot to tell you that you can also move your chair back," which he did, with manifest relief. This example illustrates how danger is often accompanied by an inability to perceive alternatives. DK presented Eli with an appreciation that the situation was not fixed and that alternatives existed to decrease the threat.

As in Carol's case, we sometimes have our outpatients medicated; however, reasons to medicate are not to eliminate psychotic symptoms but, rather, to remove whatever interferes with the sense of safety and development of trust and observation/reflection. If the collaborative effort between patient and therapist cannot contain the intensity of affect or if there is evidence from without the treatment setting that the patient is endangering himself or others, it is a good idea to medicate. Yet even when resorting to medication, the language of the symptom and its communicative function should not be ignored or eliminated. Furthermore, it is important to note that when medicating a patient, one introduces a third, whether that third is the medication and/or the psychiatrist. This third becomes the object of transference reactions that can represent either positive or negative adjuncts to the treatment. A patient may feel possessed and contaminated by the drug he ingests or, alternatively, he may feel cured and no longer in need of exploratory measures.

We wish to assert that the work we are speaking of is primarily of significance in the initial phase of treatment. When patients are present with bizarre psychotic symptoms, it is easy to wipe them out, yet this establishes the patient's mistrust in the entire system and a lost opportunity to collaborate in the meaning making enterprise psychodynamic treatment that can be when it is at its best. We all have the goal of helping the patient enlarge his or her understanding of reality, tolerate and regulate difficult affect states, and return to life with better coping mechanisms. We try to convey to patients that they have it within themselves to understand and change themselves.

Many (Bion, 1967; Eigen, 1986; Freud, 1958; Podvoll, 2003) have remarked that everyone has a psychotic and a nonpsychotic part of the self; the difference is in the degree. When patients present to us, they often use primary process and projective identification as their major source of communication. Our task is to gradually and gently introduce them to the split in their ego (psychotic vs. nonpsychotic). When the patient develops an observing ego and is able to acknowledge the limits of what they find credible (e.g., "I know this is crazy, but . . ."), we can move to a new phase of treatment in which secondary process thinking predominates. Until that happens, however, it is important not to enforce a dominant reality beneath which the patient's view of the world is erased or disregarded.

Our position derives from the radical philosophical understanding (e.g., Merleau Ponty, 1945) that emphasizes the primacy of human experience and the sovereignty of the subjective space. According to this view, fundamental reality is not separate from the subject; *the world is not ordered until experienced*. Reality is not simply what is "discovered" as being "out there" and completely subject-independent; reality includes what can be imagined and is always *interactive*.

Acts of imagination are critical and, even when imagination strays too far from the brute reality of existence versus nonexistence, presence versus absence, the possible versus the impossible, there is usually good reason for this, and it often involves a defense against annihilation. *Psychotic symptoms signal that a human being is fighting for his or her life*.

We would like now to return to the case of Mrs. G, a patient seen in both inpatient and outpatient treatment for 4 years, to illustrate how her psychotic symptoms communicated her plight and how working with these symptoms, rather than trying to rapidly eliminate them, led to a fruitful alliance, deep psychodynamic work, and significant progress.

Clinical Case

From what the nurses said, M expected Mrs. G's shouts to be rage-driven but, instead, what he saw and heard was terror. He didn't see Tony, he said, and also apologized for scaring Mrs. G. His instinct at that moment was to try to reduce Mrs. G's terror and then, bewildered by what he had "done," he felt that he was likely to recreate the situation that panicked her in the first place unless he could obtain more information from her. Even early in the treatment, it was important to clarify self-other boundaries: "Though I am sorry for scaring you," he said, "my limited view of your reality does not permit me to be watchful of your reality." To bridge the gap in their respective realities, M first asked if Mrs. G would be less uncomfortable if he were to stand directly outside her room. She said nothing nor did she back away. He told her that since he wasn't able to see Tony, the possibility of his harming Tony remained. He explained that until they could find a way together to reduce this danger he would not enter her room. He needed her help, initially

to inform him of Tony's whereabouts and ultimately to help him to see Tony himself. She said nothing more, and after a few moments, the initial meeting was brought to an end.

M returned at the same time the following day, and over the next several weeks, the daily 15-min sessions continued very much like the first one. M would stand at the door, emphasizing that he did so because he wished to cause no harm to Tony or to Mrs. G, and that until and unless they could devise a plan to protect Tony, M would remain outside the office. At some point, M's back began to hurt from standing, and so he informed Mrs. G that he needed to protect his back by sitting on a chair. In so doing, he suggested to Mrs. G that he too had something to protect, and he was also making clear that he would do what was necessary to take care of himself. Before continuing with this first phase of therapy, we wish to describe Mrs. G.

She was a short, wiry woman whose body never seemed to be at rest. There was a hyperalert quality about her as if she was always ready to spring into action. Her eyes resembled a scanning device; such was her constant surveillance of the room. She had a sorrowful and weary expression, but over the first several weeks, her terror seemed to lessen. During this time, M learned that Mrs. G had 17 "children," all under 8 years old, living with her in her small hospital room.

M began to feel that the only possibility of an alliance with Mrs. G would entail his approaching her from within her reality, as some child therapists do in play therapy (Levy, 2008; Yanof, 2013). He understood, too, that for Mrs. G to feel safe, it was essential that he not be representing a threat to her children. Together they decided that M would not enter the room until they arrived at an understanding of how M would not only not harm the children, but be of some benefit to her in protecting them. Initially, M suggested to her that she could inform him of the whereabouts of each child so that he would not harm her or him, but that placed a great strain on her since she had to do all the work. M wished to share some of burden with her if she could help M to see them.

We wish to point out that, from the beginning of the treatment, even as early as when she viewed M as a potential child murderer, his efforts were aimed at emphasizing that the two of them were in the work together. That is, both needed to feel safe to do the work that needed to be done. M needed to feel relaxed in order to think, and Mrs. G needed to feel that her children were not endangered so she could collaborate with him. They both agreed that the salient issue concerned the protection of the children and devised a plan on how to achieve this aim. After a week, M was permitted to enter several feet into the room. This was made possible by Mrs. G collecting her children around her, leaving an open space between Mrs. G, her children, and M.

M asked Mrs. G if she could introduce him to her children. Since it was Tony he had almost stepped on, he asked if it would be all right for him to be the first. Indeed, she described him with such vividness that M began to see him in his mind's eye. Gradually, she began to talk not only of his physical appearance but also about his personality. M asked if Tony ever gave her any trouble. "Oh, yes," she replied emphatically. This was the entrée into a theme that M and Mrs. G focused on throughout the entire treatment: namely, how difficult all this was for her and how alone she felt in her caretaking task.

For 6 months, M paid great attention to how crucial the children's safety was to Mrs. G and how important being their protector was for her. She became extremely defensive at the slightest hint that she might harbor any resentment toward her children. Her role as protector had to be regarded by her as entirely devoid of ambivalence.

Keeping entirely within the boundaries of the information she provided about her role as protector of her children, several themes emerged. First, that the role of protector was the essence of her identity. Second, the very necessity for her hyperalert protectiveness

derived from her view of the world as a dangerous place. Finally, remaining faithful to her caretaking role left little time for anything else in her life. This last point was slowly and delicately developed. As mentioned previously, she was intolerant of any suggestion that her role limited her exploration of other areas. She never complained. It was M who would talk at times of the burden she shouldered at having to take care of 17 children. M quickly realized that in order for her to consider the restrictions this role caused her, he had to first make very clear to her his appreciation of how important being a protector was for her and what a good job she was doing. In fact in the spirit of doing an even better job, M was able to successfully encourage her to tell him more about each of the children.

It was many months before he learned that none of these children was biologically hers. They were all orphans and shared a common heritage of having been faced with inordinate cruelty early in life. Although each child's story was unique, they all shared the sense of being the victims of a cruel world and, until Mrs. G's appearance, they lived with no adult guidance. The vividness of her detailed descriptions of each of her brood permitted M to enter into lively discussions about the children, their interactions with each other and with her, and their impact on her. It was never stated to her that the children's safety was the sole goal of the therapeutic work. Rather, the children's safety was a necessary precondition of a larger goal: Mrs. G's broadened sense of herself in the world. After all, she had been legally committed to the hospital, limiting her life in serious ways. Others, including her family, had found her impossible to deal with.

Sessions would typically begin with, "So how is Mary today?" whereupon Mrs. G would provide a detailed description of Mary's experience since the day before. And so it went until 6 months into the treatment when Tony suddenly and mysteriously became quite ill. In one of the earliest and least disguised evidences of a treatment alliance, Mrs. G told M that since he was a physician, perhaps he might be able to diagnose Tony's condition. M responded that Tony's symptoms did not fit a clear picture. Remarkably, she informed M that she didn't expect him to have all the answers and that she knew he had limits, but that she was "touched" by his interest nonetheless.

Tony fell into a coma and died 2 days later. Again, going along with Mrs. G's reality as one would in play therapy, M asked what they should do with the body. Mrs. G adamantly replied, "Don't worry; he'll just disappear." M said that might well be the case, but he very much doubted that Tony would disappear from her heart. She became quiet, looked at M suspiciously, and then burst into tears. It was the first time she had shown sorrow in his presence.

Mrs. G's grief deepened, and soon she refused food. M was torn about how to proceed. On the one hand, he was convinced that mourning was essential for her progress, especially since it seemed that loss was at the center of her problem. It was important for her to develop the capacity to tolerate loss. On the other hand, there were 16 other children who would have to be dealt with. So, even though M was gradually chipping away at Mrs. G's masochism as a path toward living a selfless life in which she nonetheless was at the center, he decided at this point to utilize her masochism in a constructive way. "I know this is asking something almost impossible for you to consider in your grief, but think of the other 16 children," he said. "They need you. Only by releasing Tony can you fully give to those who remain."

Over the next year of treatment, 15 children perished. The general outline of her experience with Tony's illness and death provided the template for these other experiences. Grief was followed by an awareness of her responsibility to the "living." Her grief was intense, and M and Mrs. G often sat together in silence. Whenever she refused to eat or, during one occasion when she became catatonic, M reminded her of her responsibil-

ities to the living. Although obvious, never once did he directly interpret that the responsibility to the living was, of course, to herself.

Once M slipped and suggested to Mrs. G that perhaps she took on such an enormous task because she felt badly about herself. Outraged, she began screaming and told M he was crazy. "Maybe that's it!" she announced as if reaching a novel insight. "That's why you've never called me crazy for having these children no one else can see. Maybe you're an ass!" Thanks to the growing working alliance and the strengthening of the nonpsychotic part of Mrs. G's personality, she was more comfortable asserting herself. At that moment, M realized his interpretation had been premature and dangerous. As with other conditions, when working with psychosis, it is vital to leave certain issues on the backburner, sometimes for a very long time. In an attempt at reparation, he reflected, "It's clear that what I just said was quite hurtful to you." Because they had already established a strong working alliance, Mrs. G and M were able to repair the rupture caused by M's premature interpretation.

Each loss of a child was deeply felt. It even appeared that each loss produced more intense grief than the previous one. When M remarked on this, Mrs. G convincingly explained, "Sure, each time I am less scared to feel things. Didn't you know that?" M assured her that he did not ask questions that he already knew the answers to, but her question allowed him to stress the theme that he emphasized at every opportunity—namely, that she was the principal informant of her life and that what he knew about her, he learned from her.

We would like now to skip ahead to the first half of the third year of treatment, a strenuous time that was dominated by the dying and death of Mrs. G's last child, Jennifer. Her grief was so intense that M began to feel hesitant about the nature of the work. He wondered to himself whether he had gone too far in encouraging her to confront her losses. His countertransference was most clearly revealed to him when he found himself repeatedly encouraging her to be angry at him. "You must be angry with me for what's happening," he'd say. Since she had not indicated that, M realized that he wanted her to punish him for what he felt was his error in causing her a great deal of suffering. On a deeper level, he came to recognize that it was easier for him if Mrs. G blamed him rather than sit with her through the agonizing expression of her grief. "If Jennifer dies there will be no reason for me to live," she exclaimed while refusing all nourishment.

Despite her request to be allowed to die, M finally gave the order for Mrs. G to be fed by tube. The decision to force-feed Mrs. G helped resolve M's countertransference because her starving herself compelled him to confront two issues: first, whether he had the right and responsibility to decide whether she could live without Jennifer and, second, whether the therapy was based on an unjust decision on his part to pursue a strategy of relinquishment in the service of autonomy. As he pondered his function in the treatment, he realized that, whenever he had faltered, it was Mrs. G who gave him a sign to keep going. His guilt was now getting in the way of what she had taught him. So in resolving to keep her alive, he was also telling both of them that they could—and would—continue their work.

Mrs. G tried to pull out her feeding tube but, curiously, did so only when the nurses were present, thus provoking them to anger. M pointed out to her that she had shown no defiant behavior with him, and he wondered with her whether there was a part of her that wished to continue their work and therefore not to alienate him as she had the nurses. He wondered to himself as well whether the reason she had chosen to provoke the nurses was because she had sensed that he had wanted her to punish him and therefore she would not

get the same response from him as she would from the nursing staff. Their anger deflected her focus away from her sorrow.

After this discussion, Mrs. G ceased her selective tube pulling and informed M that the tube was no longer necessary and that she was ready to be on her own. M remarked to her that her poor nutrition was weakening her. "I know Jennifer's going, and I want to remember everything," she said. "Maybe memories are all that I will have." Since M was unable to "see" Jennifer, Mrs. G suggested that she might draw him a sketch of Jennifer and that she and M could collaborate as to the accuracy of the sketch. The sketch took nearly 2 weeks to complete. Each session began with Mrs. G describing how Jennifer looked and M offering suggestions about how to make the drawing a more accurate representation of what she was describing. The drawing was clearly a transitional object (Winnicott, 1975) to help Mrs. G in her grieving process. It also was Mrs. G's attempt to make something real in the world she increasingly shared with her therapist, an object that they cocreated. One day, M asked Mrs. G what she would do with the finished drawing. "Maybe I'll tear it up; maybe I'll frame it," she answered matter-of-factly. M said that her choice represented the two ways she could deal with Jennifer's loss: remembering her or trying to rip her out of her mind. Jennifer died the next day.

The next 3 weeks were very solemn. M joined in Mrs. G's grief, telling her that he, too, had no words at the moment. For the most part, they simply sat together in silence. But he did ask Mrs. G whether the framing part or the ripping part was winning out. Like M, Mrs. G happened to be Jewish, so one day M told her their situation reminded him of sitting shiva. To his surprise, she remarked that no one had ever sat shiva in her home. What was so astonishing was not the fact that no one had sat shiva, but that Mrs. G was sharing, perhaps for the first time in 3 1/2 years of treatment, something about her life before the psychosis had taken it over.

M knew he was on precarious footing, lest Mrs. G slam the door on her past. Yet he wished to take advantage of this opening, so he ventured to say, "You know, for the last 3 1/2 years, we've never talked about anything outside this room." She replied curtly that she had been far too busy taking care of her wards to do so. M asked her whether they might continue to move forward without turning their backs on Jennifer and the others. He tried to reassure her that everything in her life had meaning and that there was a relationship between Mrs. G's life with the children and her past. M asked her to think about whether there might have been anything about what happened to her before the children that could help them understand why she had taken on such an enormous task. He also questioned whether what she had done with her life with these children could help them comprehend how she experienced what had gone on before. She replied that it was all too confusing for her and that M was rushing matters.

The truth is that Mrs. G was correct and that M's rush to analyze the connection between Mrs. G's distant and recent past was premature and largely influenced by his newfound awareness that he was going to move within a year and had felt pressured to tidy things up before he left. Over the next 6 months, Mrs. G taught him that his need to get everything neatly tied in a bow was disrespectful of her considerable strengths, which she had demonstrated repeatedly. After all, 17 very important people had left her already, and she had survived. Why she had taken the path she had, in a very real sense, added surprisingly little to what they already knew.

Despite her protests about rushing things, Mrs. G did reveal that she had been an only child. Her father frightened her because he was always yelling at her, and she felt, from a very young age, that he hated her. She tried to hide from him, especially when her mother wasn't present. It did not appear that she had been sexually abused. Mrs. G

idealized her mother, especially because she felt her mother had tried her best to protect her from her father, even though her efforts were largely ineffectual. Mrs. G often thought about running away from home, but she never did so because she feared some harm would come to her mother.

She was only 8 years old when her mother died. She remembered being frightened all the time after her mother's death and felt even more unprotected than she had before. As she recounted this, she laughed and said that she knew it was crazy, but she had a feeling that perhaps her father would be nicer to her once her mother was no longer in the picture. Sadly, this was not the case.

Three years after her mother's death, another woman moved into the house. Mrs. G's father never married her but demanded that G refer to her as mother. She refused to do this, and one day the woman told Mrs. G that everything was her fault, that her parents had married because her mother was pregnant, and if she had "never happened," everyone's life would've been better off. Mrs. G was 15 1/2 at the time. She finished high school and then went to work for the American Society for the Prevention of Cruelty to Animals (ASPCA), a job she liked very much. She said she felt a kinship with the animals because they had been given away, which she equated with having been unprotected. It was with a great deal of sorrow during these sessions that she questioned imploringly, "Why didn't anyone want to protect them? They were so helpless!" Mrs. G described a "birthday" ritual she devised whenever a new animal was adopted and emphasized how the life of the person doing the adopting was completely transformed. These private celebrations were high points in Mrs. G's life. It was soon thereafter that she developed her delusional system.

The reason she was admitted to the hospital was because she refused to let her landlady into her room, fearing the mayhem that would affect her wards. The landlady nonetheless insisted, claiming that she had to see how well kept up the room was. Mrs. G became paranoid, and she barricaded herself inside her apartment, leading the landlady to call the police.

The discussion of her past was given in a rush. Within 3 sessions, she had blurted out her entire history. The remaining time was spent, as she put it, "connecting the dots." M and Mrs. G discussed how much she had wanted to protect her wards, and yet all of them died. Mrs. G instantly associated to several memories of the times her mother had successfully protected her, as well as the times she had failed. What was even more surprising was that she had also recalled several richly detailed memories of her father having taken care of her. With a great deal of wistfulness and irony, she insightfully came to appreciate the great paradox of her adult life: as important as the children had been for her survival, to that extent was it necessary for them to die in order for her to live. Yes, she agreed; the children had to die but only after she had acquired enough of what she called a "base." And who had provided that base? The answer was the children, of course. Mrs. G and M never discussed whether the children were real.

We would like now to turn to some points that can be gleaned from this illustration in terms of working with the symptoms.

1. *Take what you can get.* Symptoms are what the patient offers us, and therefore, they are the material we have to work with. Often patients with psychotic symptoms are extremely wary, watchful, and guarded. Thus, it is helpful to meet them where they are in order to establish a therapeutic alliance (Frank & Gunderson, 1990; Selzer, Sullivan, Carsky, & Terkelsen, 1989).

2. *Respect for symptoms comes as a surprise to patients.* Patients are so accustomed to others, including and sometimes especially professionals, not respecting their view of life. This surprise element has advantages for arousing their curiosity and willingness to work.
3. *Give credibility to the patient's strengths.* Rather than treat symptoms as signs of a disease, it is helpful instead to regard them as efforts, however flawed, at adaptation and caretaking. Significantly, Mrs. G lost her mother when she was eight, and her wards were all under the age of eight. Here was a clear connection that highlighted the way she employed her imagination to vicariously mother herself after her own mother had passed away.
4. *What is the patient adapting to?* Many think there is a person hidden underneath the schizophrenic symptoms that needs to come out. We are saying that the person is revealed in her symptoms; symptoms are the window to the person.
5. *Symptoms are a way of attenuating affect.* Mrs. G was unable to say she was lonely or needed a hug. Yet, she created children whom she could hug and express affect toward at the limits of her tolerance.
6. *Symptoms have tremendous heuristic value.* By paying attention to symptoms, we assume they will eventually lead us to a greater understanding of the context in which the symptoms arose as well as the patient's meaning making system.
7. *There is continuity in personality.* Once we understand that adaptation arises from somewhere and attempts to get somewhere else, then we can help patients appreciate the continuity in their lives. This point attacks the notion of a "break" between a before and after state and, instead, values the symptom as a bridge that helps build a coherent and continuous sense of self (Selzer & Schwartz, 1994).
8. *Establish the authority of the patient.* Even if the patient's symptoms appear like a riddle, one can nonetheless communicate that they are meaningful and credible, though puzzling.
9. *Symptoms offer a clue to major issues.* Within the first 5 min of meeting Mrs. G, her symptoms made it obvious that she was living in a dangerous world in which she was assigned the role of protector.
10. *Symptoms are driven by intelligence and logic.* It is wrongly assumed that symptoms are emotions gone berserk. If one takes the time to understand the meaning of symptoms, one is able to appreciate the enormous logic they contain.
11. *Symptoms communicate.* No matter how tentative, confused, or smoke-screened they are, symptoms are an effort to reveal something. In Mrs. G's case, the paradox of her life was revealed through her symptoms: she needed the children to live and yet she also needed them to die so that she could go on living.

Conclusion

Our model of working with psychosis differs from that in current practice, despite the fact that both models focus on symptoms. The medical model employs the *DSM* to ascertain which symptoms are present in order to diagnose and categorize a mental illness. Our model also looks closely at symptoms. But we are not advocating assessing their presence or absence for diagnostic purposes. Rather, we use symptoms as guides to understanding the patient's dynamics and as invitations to embark on collaborative work. Thus, instead of focusing on symptoms as signs of pathology and disease or disability, we regard

symptoms as creative attempts to adapt and survive. Focus here is on the patient's strengths rather than her weaknesses. Viewing symptoms as a pathway toward alliance, collaboration, and meaning making, rather than obstacles and resistance to be eliminated, offers hope to the therapist as well as the patient. Recent efforts are being made in communities of those who hear voices (e.g., Hearing Voices Network), where voice hearers learn to understand and live with their voices rather than rush to eliminate them (Dillon & Hornstein, 2013; Romme, Escher, Dillon, Corstens, & Morris, 2009).

Mrs. G began treatment with the conviction that she needed to preserve the lives of her many orphaned children without understanding how or why such a daunting task became hers. She held onto the belief that mourning would result in disintegration and therefore devoted her life to a defensive system that precluded mourning. Mrs. G gradually developed the affect tolerance necessary to withstand the many losses she faced together with her therapist. Significantly, with each loss, she was able to feel more and to grieve more. Finally, all of her wards were gone allowing Mrs. G to turn to her own interrupted life and "connect the dots." She had become a mother to her imaginary "orphaned" children as a way of taking care of the abandoned parts of her childhood self as well as identifying with her lost mother. Now that Mrs. G's symptoms made sense to her, she was able to let them go.

We are well aware that most mental health practitioners do not see psychotic patients in their outpatient practices. Yet we hope that this article will entice these same people to see the many Mrs. G's in the world who will respond well to collaborative work that includes recognition of the meaning of their symptoms as well as their attempts at adaptation and communication. Even if one's major approach is pharmacology, then we believe that a de-emphasis on compliance and adherence is positively affected by an increased focus on collaboration. We are not positioning ourselves against psychopharmacology. Indeed, we believe that medication regimens have a better chance of being adhered to if the treatment relationship is a collaborative one that includes respect for what the patient is bringing to the table (Corradi, 2004; Docherty & Feister, 1985). If our article gets readers to pause the next time they encounter psychotic symptoms and ask what they might mean and what they are being invited to share, then we have succeeded in our aim.

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