Lectures

L 01
Individuals fallen ill with schizophrenic psychoses - the least understood persons in our world.

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Individuals who have fallen ill with the schizophrenia group of psychoses are still the least understood persons in our culture. Why is this so? – and especially why is this also so with regard to the professional persons who work with them?
It seems certain that the most fundamental reason for this is that these people are not encountered as individuals with serious problems but as victims of an illness which has to be subjugated. During my now sixty years as a psychiatrist I have read dozens of times about a newly found biological background to "schizophrenia" – later to be shown to be based on erroneous, or at least exaggerated, conclusions. Besides the ambitious hopes of researchers, this undoubtedly also reflects a wish to repress the part played by interpersonal relationships because of the anxiety they are prone to bring about – something which is very understandable especially on the part of those with whom the patients grew up.
At least in my country, Finland, there is also an exaggerated emphasis on diagnostic classifications with their itemized lists of symptoms in the training of psychiatrists. It took too large a place in training compared with the time needed to learn how to approach and psychologically understand the patients and their problems.
The term "schizophrenia", originally presented by Eugen Bleuler in 1911 in the form
"Die Gruppe der Schizophrenien" has nowadays became questionable, very justifiably. I myself wrote, in the beginning of the book "Psychotherapeutic Approaches to Schizophrenic Psychoses" we edited some years ago (Alanen et al., eds., 2009): "The clinical heterogeneity of schizophrenic patients makes us ask whether it is even justifiable to speak about an illness called 'schizophrenia'. Such diagnostic practice certainly has disadvantages for both research, where notably dissimilar patients are placed in the samje diagnostic clusters, and for individuals, who continue too often to carry the diagnostic label even after their recovery."
I still use this term in my presentation, because I have done so all my life, and because I think that the most important thing for us is to develop treatment of these fellow-men and women, notwithstanding how we call them.
Notes on research
The lack of a more personal relationship with patients also easily leads us to forget that the group of schizophrenic psychoses is a very heterogenic entity of persons whose symptoms, life situation, prognosis and also suitability for different treatment modes may vary very much from one case to another. As referred above, this is apt to create problems not only for the development of treatment but also for researchers and the results of their studies. I will take an example. We know that there is a schizophrenia group of patients who rather easily develop a motivation for psychodynamic individual psychotherapy and also benefit from it, and, on the other hand, patients with which the establishment of such kind of therapeutic relationship is, in practice, hardly possible. However, in statistical analyses of random studies the opposite findings (improvements and a deteriorating course) cancel one another out leading to the false conclusion that this kind of therapy is not effective with schizophrenic patients.
Biological hypotheses still dominate the study of the aetiology of schizophrenic psychoses. Even if it is naïve to deny all connections between psychotic breakdown and brain biology, every spe-

cific theory of organic aetiology still lacks verification. Recently, in a paper published by the group around Nancy Andreasen, who has been the leading representative of the popular brain theory of schizophrenia as a degenerative condition it was reported that the diminishing brain-ventricle proportion, found in many chronic 'schizophrenic' patients most probably is not caused by a degenerative brain process but rather by heavy long term neuroleptic medication (Ho et al., 2011). We may respect such sincerity of this research group . For myself, the degeneration theory seems not plausible because many patients permanently recover – or even become more healthier than before– either spontaneously or due to the effects of therapy.

Generally, the theory that is most supported as aetiological in the schizophrenia group psychoses is that of genetic influences. As a result of intensive molecular genetic research, many genetic traits (chromosome regions, mutant genes and/or genetic aberrations) have been found which may contribute to a predisposition to the schizophrenia group of psychoses, varying considerably from one study to another. However, the existence of any specific ''schizophrenia' genes" is now considered unlikely.

There are investigators who, while speaking of environmental factors in the aetiology of schizophrenia only refer to the biological environment, including complications experienced during mother's pregnancy and labour. I don't know if the geneticist Kendler agreed with this when he expressed his frequently quoted conclusion that genetic factors correspond to 80 per cent of the aetiology of schizophrenia. Anyway, I doubt very much that it has yet been possible to directly differentiate from each other genetic factors from those connected with the psychological environment in which growth takes place

Fortunately more integrating views on these matters have gradually begun to strengthen, not least those achieved by some broad-minded biological investigators. Nobel-prize winner Kandel (1998) already strongly underlined 15 years ago the holistic plasticity and adaptability of cerebral functions and their constant interaction with the environment. Through continuing interaction genetic and enviromental factors shape the formation and functionality of the neural web, including its psychological development and its disorders. Kandel still excluded 'schizophrenia' from this unity considering it to be a separate category, a point with which I strongly disagree with him.

Relationships with other people, beginning in first days of our life, are not only an aspect of human psychology, but also are a part of human biology, necessary for our development into adult human beings (Alanen, 1997). This is best exemplified by the findings made in the rare cases in which human children have grown up in the wild, surviving under animal care in a warm climate, without any human contact: they did not learn to speak, their facial expressions are undeveloped and even their drive functions functions remain rudimentary (Malson 1972, Rang, 1987).

Psychodynamically oriented studies of the childhood family environments of schizophrenic patients had their ground-breaking period during the 1950-1970s when several American teams – especially those around Theodor Lidz (Lidz et al., 1965) and Lyman Wynne (Wynne & Singer, 1963) – made their studies, finding different interpersonal constellations which were pronounced in many of them. My own career as a psychiatric researcher also began with a study of 100 mothers of schizophrenic patients (Alanen, 1958). However, a taboo on these studies and publishing their results then occurred , largely due to the powerful Parents Association in the U.S. In an influential treating program published at the end of the 1990s by a team of U. S. Institute of Mental Health investigators (Lehman et al., 1998), psychodynamically oriented family therapy with 'schizophrenic' patients was firmly forbidden.

The rejection of these findings was partly provoked by insufficient empathy shown towards the problems of these parents by us family investigators ourselves. It is said that in particular an inconsiderate New York presentation by the Italian family therapist Mara Selvini Palazzoli – (who was well-known to many elder participants of these ISPS symposia) deeply offended parents. Nevertheless, family studies have added greatly to our understanding of the psychodynamics

of schizophrenic psychoses, especially throwing light on their long term developmental history, both at inter-generational and individual levels and, most importantly, offered us a new way to help both the patient and the members of her family.

Heterogenic nature of pathogenic factors

I have presented my own view of the development and course of the 'schizophrenia' group psychoses in the enclosed Figure 1 (cf. Alanen, 1997).

The heterogenic nature of the 'schizophrenia' group should be remembered here. The pathogenesis of psychoses is both multi-faceted and multi-layered, the importance of different factors varies much from patient to patient, and not all of them are present in all cases.

Predisposing Factors

Uppermost in Figure 1 we find the crucial biological and psychosocial predisposing factors. It is important to emphasize that we often can here assume a mutual interdependence between them: e.g. a child whose genetic constitution seems to be most passive or drawn to autistic tendencies among the family's children may easily be "selected" by the mother (or, sometimes, by the father) to satisfy the parent's symbiotic needs (that refers to a psychologically vital dependency), resulting in an unconscious hindrance to the child's individual development. Mutual inter-connection between genetic and environmental factors was found also in the large adoptive study by Tienari and his group studying the effects of disorders of rearing environment to the psychological development of adoptees with psychotic biological mothers, on the one hand, and control adoptees, on the other (Tienari et al. 2004, Wahlberg et al. 2004).

Precipitating Factors

I would here like to call especial attention to two factors among those mentioned among the precipitating factors of falling ill: narcissistic traumata (blows to self-esteem, rejections and humiliations) and – as a somewhat more long-range factor – conflicts and situations related to separation including both loss of people close to oneself and, rather often, one´s own attempts for greater independence, turning to be ambivalent and unsuccessful. These factors were found to be significant and common in the study by my colleague and friend Viljo Räkköläinen (1977), findings which he published in his monograph "Onset of Psychosis, a Clinical Study of 68 Cases".

Understanding concretized language as a way to therapeutic relationship

What happens when the psychosis breaks out? At the level of brain biology we cannot answer this question, t at least I cannot! . At the psychological level we are talking about a breakdown of the integrity of the ego, at least partial, that arises either suddenly or gradually, and usually accompanied with building anxiety. The amount of damage to the ego varies; it may stop at the level of paranoid delusions or lead to more extensive disorders of thought and hallucinations. In connection with these , the term mental fragmentation is often used. I do not like this term very much, both because it is here a question of regression backwards in the development of thought, often best characterized by a concretization of thinking, typical also of our own unconscious as experienced esp. in our dreams. Understanding this level of thought functions may help us considerably to understand many of the expressions of people with psychosis.

My best teacher in this area was my patient Eric, a gifted man who - after about ten years individual psychotherapy begun during the 1950s – finally became a university professor in his field. I have described him in my book "Schizophrenia – Its Origins and Need-Adapted Treatment" (Alanen, 1997). During a couple of our first sessions, he mostly stared at me hesitatingly (he later told me that he suspected that I might be a member of an American gang conspiring against him). In the third session, he became more trustful and, amongst other things, called himself a car, because other people could control him as they were able to steer a car. He asked me to steer him. I said that I would rather be a driving instructor who would teach him to steer himself. I assumed that Eric, despite his psychotic experiences of being influenced from outside of himself , could understand this symbolism, and at "first-degree level" he certainly did. Still, one morning he called

to me in an extremely worried state, telling that he had received a telephone call (apparently to a wrong number) asking whether he had a car to sell.

Eric had begun to live increasingly in a world of delusions of reference. In connection to this, he used the name "second-degree language". By this he meant that there were hidden meanings pertaining to him that were implicit in the speech of others. For example, when a man in his company looked out of a window and said, "It's getting overcast", Eric considered tha this was an expression of that man's increasing hostility towards him. In these kind of experiences, some 'schizophrenic' persons (including Eric) may have a kind of double book-keeping - as already Eugen Bleuler (1911) has remarked : on the one hand, they understand that they should not speak about things like this openly, because other people may find them ill; on the other however, they themselves still believe that they are real.

An example of a more seriously ill, concrete and omnipotent world was described by a young man, who whilst on our hospital ward in Turku claimed that wars and unemployment would have been eliminated from the world if his relationship with his first ever female friend had not collapsed. We might very well consider that if the relationship had continued, this might have prevented his illness – at least temporarily – as well as his later violent tendencies and unemployment?

Notes on psychotherapy

All 'schizophrenic' patients, especially the younger ones, have increased symbiotic needs, even if covered by autistic withdrawal or other defensive psychology. When patients are encountered by a therapist in an empathic, not too intrusive way, a symbiotic1 transference relationship will appear, usually gradually, but with some patients rather rapidly. Many of these patients are able to establish a good and faithful individual therapy relationship, even if easily traumatized by separation situations Their transference relationships are rather often connected with the fact that they have been important children for their parents, with relationships characterized by mutual, increasingly ambivalent symbiotic binds. Such patients are better suited to a long term psychodynamic individual psychotherapy than are many borderline patients with low object constancy. For these patients, the therapist soon achieves the position of an empathic person able to be used in the service of development (developmental object was the term used by the Finnish psychoanalyst Veikko Tähkä, 1993). For the patient, the work within the positive mutual transference and countertransference relationships involves an identification with the therapist and his/her attitudes. This may help the patients psychological growth even more pronouncedly than with less disordered patients. A relatively similar background between the patient and the therapist– with regard to a common kind of social environment, education etc. - may be a helpful contributory factor here. However, it is good not to forget that the work of the therapist is not only standing under the sun; aggressive transference feelings will also arise (sometimes stimulated also by the therapist's actual behaviour!) and the expressions of this aggression is something that the therapist should bring out from their hiding places.

Besides transference interpretations I have found interpretations upwards especially useful in psychosis psychotherapy; by this I mean making a "translation" of the patient's concretized psychotic expressions into normal language. I will also give an example here which is found in my book that I mentioned earlier.

This patient, Paula, had a delusional belief that part of her brain had been removed by operation in the hospital ward. When I said that she might be thinking this because she has a feeling that now that she is ill and in the mental hospital, she is not as able to think as clearly as earlier, the delusion disappeared. However, it is important to state that a precondition for this success was also her instinctual acceptance of my empathic attitude, experienced by her in our earlier discussions in the ward. This helped her to give up her delusion that had been characterized by an accusing and hostile attitude towards us.

According to my opinion the psychoanalytic theory of schizophrenic psychoses has, in its almost

exclusive emphasis on the disturbed early mother-relationship, contributed to the fact that a more extensive picture of patients' nurturing environment has remained incomplete. There are certainly schizophrenic patients with a history of a very frustrating early childhood. However, in many other cases I found in my studies – as I have already pointed out - family environments characterized by continuing mutual symbiotic relationships between the patient and his/her mother, or sometimes the father, well beyond early childhood. Through deeper investigation we are usually apt to find reasons for this on the parental side, for example in unsatisfying relationships with the marriage partner, and, at their base , predominantly unconscious, in the more extensive family dynamics including the parents´ own relationships with their parents.. With these kinds of findings in mind it is easy to empathize also with parents, instead of blaming them for their children's illness. I have the experience of some family therapies in which the mother switched a considerable part of her symbiotic needs onto me instead of her adult child, and would then begin to incorporate some of my attitudes into her own attitudes towards other family members, with the result that the patient gained more space for her/his growth and began to develop more contacts outside of the family. However things do not always go so smoothly.

Following the terminology used by Helm Stierlin (1974) when developing his "transactional modes" of intra-familial relationships, I have used, in connection with these mutual symbiotic relationships, the term "transactional defence mechanisms" (Alanen, 1978, Räkköläinen & Alanen, 1982). By relying on other people or fantasies of them, these defensive functions serve to protect the person from anxiety caused by internal or external threats – most typically separation anxiety, but sometimes also a threat to parents' compelling own needs that they delegate to children. Whether their anxiety is successfully warded off depends on whether the other person behaves in the manner expected from him or her, or whether such fantasies at least can be sustained.

Such parental psychology is, of course, common in most families, but often especially strong and leeds to the breeding of unbearable ambivalence in the environments in which our patients have grown up. A most illustrative example of this was the father of the Australian pianist David Helfgott who fell ill with a 'schizophrenic' psychosis. The film "Shine" is based on a faithful description of the pianist's life. There also the background of the father's (masterly played by Armin Mueller-Stahl) stone-hard binding delegations found within the frustrations of his own childhood history that was revealed.

Many psychoanalyst-therapists have a somewhat mistrustful attitude to family therapy and especially to combining it with individual therapy. However, according our experiences, a family therapeutic process at an earlier phase (often now carried out by a team), may considerably increase the possibilities for a successful individual therapy and also arouse the confidence of the family members in the individual therapist – be he a member of the therapy team or not. For family members, the confidential nature of the individual therapeutic relationship can be then pointed out.

Beginnings of the need-adapted orientation

When I 1968 was appointed to my professorship in psychiatry in Turku University, I also became head of the university hospital named Turku Psychiatric Clinic. Our clinic was, together with another psychiatric hospital and a municipal Out-patient office , responsible for public psychiatric care in the Mental Health District of Turku, a city of somewhat less than 200 000 inhabitants.

Here I met a group of bright pupils who were very interested in psychodynamic psychotherapy. Many of them also shared my interest in psychotherapeutic treatment of the schizophrenia group of patients, becoming my permanent co-workers over many years. Our developmental work was based on close mutual team work in which we all had the benefit of each other's' ideas.

We decided to develop a long term project for our psychotherapeutically oriented approach especially for the treatment of first-admitted 'schizophrenia' group of patients. The centre of the work was our clinic, but we also formed cohorts including all the patients admitted to various

units in the district in order to study, through follow-ups, the effects of our developmental work in the district as a whole.

In the PP slides 2 and 3 enclosed, our general goals are presented and also some important preconditions for the successful development of our project.

It was not question of a quick innovation, but of a gradual process including training and supervision programs and, most importantly, development of a multi-professional psychotherapeutic community including a shared empathic basic attitude towards the patients, open mutual communication and various group activities. The nurses have a key position when we are developing increased therapeutic resources in the field of public mental health. The psychotherapeutic needs of a population can never be met only by psychiatrists and psychologists. According to my opinion, psychosis psychotherapy, in which the significance of empathy is especially pronounced, is more suitable to the practise of nurse therapists than the more "technical" psychoanalytically oriented psychotherapy of neurotic disorders. And with these patients, even a small level of improvement may have a very remarkable influence on the patient's course of life.

At first, our main emphasis was on individual therapies of this kind. With some co-workers we have published a follow-up study of our nurses' psychotherapy (Aaku et al., 1980), confirming our ideas and also confirming their good results in many cases.

However, the individual therapeutic relationships could reach only a part of patients . It was also noticed that there were obvious differences between therapeutic needs of one group of schizophrenia patients and others, with limitations in our capacities to provide for the needs of these other groups, and that we should develop our work considering this fact. This led to the term need-adapted treatment, originally coined by our team members Viljo Räkköläinen and Riitta Rasimus. In the course of a follow-up investigation they clarified what had probably been the most appropriate therapeutic measure in the case of different patients. (The term was, at first, "need--specific" treatment, but was changed to "need adapted" because this is more flexible and gives more space to changes of treatment which is necessary to do in many cases during the treatment process).

Family-centred therapeutic work in this early phase was overshadowed by the interest in individual-centered work. One of the reasons that became evident was the lack of basic training in family centred work, compared with psychoanalytically oriented training programs in individual psychotherapy that already existed in our country. To correct this shortage, at the end of the 1970s I made an initiative with the Finnish Mental Health Association to arrange ordinary family therapy training (systemic /psychodynamic) in Finland. Besides psychosis psychotherapists, this training programme was very welcomed also by the staff in the fields of child and adolescent psychiatry. The training was put into effect first in Helsinki and Turku, and then it was spread to different parts around the country.

Many co-workers at our clinic acquired this training. Some of our team members developed the idea of meeting new schizophrenia group patients together with their family members right at the beginning of their treatment, in many cases continuing these meetings for some time. (PP slide 4) The results were surprising (at least to me): the state of several patients began to improve rapidly and sometimes all psychotic symptoms disappeared. Klaus Lehtinen, who was one of the initiators of this practice, later made a five years follow-up of this cohort, finding that its outcome still at that phase was clearly better than those treated earlier. 60 per cent of the patients first-admitted with a diagnosis of schizophrenic group of psychosis according to DSM-III-R did not have any psychotic symptoms at five years follow up, compared with 40 per cent in the group treated earlier, where the emphasis was on individual psychotherapy (K.Lehtinen, 1993).

We began to call these meetings therapy meetings. As presented in PP slide 5, their functions can be divided in three parts, closely connected with each other: informative, diagnostic and therapeutic. From a psychodynamic perspective, their effects include a considerable strengthening of

the patient's self–esteem by involving him/her with us and the family members in the discussion of his problems and treatment, listening to his opinions at the same level as those of the others. Psychologically most important is also the satisfying effect of our support to the patient's – as well as many other family members - symbiotic needs, pronounced in this difficult situation. PP slide 5 itemizes a number of other therapeutic advantages, more or less present in different .

Even if the family-centered activities, including in many cases longer family therapies, our individual therapies also continued in almost the same amount as earlier. The follow-up results presented above should not be taken as a comparison between individual and family therapies. Besides the beneficial effect brought by therapy meetings and other family-entered activities, I would like to emphasize a very remarkable change in the increased unity of our treatment orientation: while individual therapies were restricted to a part of patients, family therapy meetings could be carried out in the great majority of cases. In the cohort presented above it was carried out in 87 per cent of the cases. The families in this early phase were often very anxious and motivated to seek support. In cases in which we could not meet the family, we invited other people close to the patient, e.g. a friend or companion of a young person studying in Turku. Therapy meetings were not restricted to the treatment of first-admitted patients with psychosis but were also practised with re-admitted patients and their families.

For the further development and results of the Turku project, cf. Alanen 1997; Alanen et al., 2000. What about the use of neuroleptics (slide 7)? We have their use, in small or, temporarely, moderate doses, to be a treatment mode supporting psychotherapeutic and psychosocial activities in many cases. However, a treatment restricted only to renewing prescriptions of neuroleptic, or giving them as hypodermic injections to half-unwilling patients is, according my opinion, a rather primitive way to treat these people , perhaps even an offence to their human rights.

During the 1980s, the principles of need-adapted treatment of the 'schizophrenia' group of psychoses spread out in several mental health districts in the framework of The Finnish National 'schizophrenia' Project. A very interesting six-centre study was also made, with a special focus to study the results of the need-adapted treatment of first-admitted patients with non-affective psychosis without neuroleptics (V.Lehtinen et al., 2000). During the succeeding decades, however, the development met with setbecks in many districts, because of a lack of support and even active opposition from the side of prejudiced biologically oriented university professors and their students. However, there were also districts in which the work has continued and even developed further, as best exemplified by the Western Lapland project with its Comprehensive Open Dialogue Approach (Aaltonen et al,, 2011; Seikkula et al., 2011). There the activities have developed towards a larger social-psychiatric orientation, increasing contacts with other mental health and social services. These Finnish activities were presented in the pre-conference workshop in the symposium "Need-Adapted and Open Dialogue Approaches", arranged by my friend and earlier co-worker Jukka Aaltonen, who has had a crucial role in the establishment and later development of these Finnish projects.

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Last of all, I will return to the beginning of my presentation: why are our fellow-men and women who fallen ill with the schizophrenia group of psychoses still the least understood persons in our world? I remember a sentence established by my able secretary when we were preparing the final report of the Finnish National Schizophrenia Project almost thirty years ago, Anita Kokkola (who also had training as a nurse specialized in psychiatry). She asked herself the question: What would be the best attitude towards 'persons with schizophrenia problems and answered: The best attitude towards persons fallen ill with schizophrenic psychosis would be the same attitude which

is the best for all of us. This reminds us of the famous statement by Harry Stack Sullivan, emphasizing that persons with schizophrenic psychosis "are more human than otherwise". Because of our prejudices and even fears, we still are prone to find them as "being otherwise" and isolate them from us others, both in our mind and in our actual practise towards them.
Our task is to increase our understanding of persons fallen ill with psychoses and to stand up and oppose their psychological isolation, not to make it worse.

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L 11
More Simply Human: On the Universality of Madness

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I am honored to have been asked to address this meeting of an organization I have admired for years. Many of you have considerably more experience than I do working with patients diagnosed as psychotic, and yet when I received the invitation to keynote this conference and protested that my own clinical experience with acutely psychotic people was too limited for my thoughts to be of value to this audience, I was told that I was welcome anyway, and that my reflections on psychosis and our current ways of conceptualizing and engaging therapeutically with it would be valued here. So I accepted the invitation, and I hope to be worthy of the confidence of those of you who suggested inviting me.

I want to talk today about the broader, timeless concept of madness, of going or being driven crazy, with an emphasis on, and a critique of, contemporary approaches to naming and cataloguing ways of being mad. I believe that the current conventional wisdom about the nature of psychosis arises in part from efforts to manage profound anxieties about what I will argue is a universal human vulnerability, not a tragic brain glitch that befalls only the unlucky few. I want to speak not only for the age-old wisdom that what can destroy sanity is the unendurable pain of a hard life, but also for a way of thinking about extreme psychological states that I worry is a dying sensibility among most people with the power to make mental health policy.

Implicit models and metaphors inevitably frame the terms of public and professional conversations. Throughout history, madness has been implicitly conceptualized in two somewhat incompatible ways: categorically, as a discrete phenomenon, and dimensionally, as an exacerbation of universal vulnerabilities of the self. Each tacitly assumed, underlying paradigm is a defensible way of construing madness, and each offers something of value for those of us who want to be helpful to our most anguished patients. But today I will argue that in recent decades, the ascendance of the categorical model at the expense of dimensional considerations has greatly diminished our capacity to think usefully together about psychotic suffering and its potential amelioration.

Categorical notions of psychosis imply that some of us are essentially sane while others are afflicted with madness; dimensional assumptions suggest that we are all both sane and potentially crazy, with different degrees of sanity and madness at different times. The categorical conceptualization suggests that one either "has" or "is free from" psychotic illness, while the dimensional position implies that under sufficiently adverse circumstances, any of us could go mad. Both conceptualizations capture elements of the lived experience of psychosis, and both have been valuable as heuristics to help us organize and study the phenomena we include under the umbrella of the psychotic. But because they have profoundly different ramifications, it is of concern when one or the other assumptional bias comes to define the terms by which we talk about psychotic suffering and silences any reflections from the other perspective.

Categorical paradigms, whether the ancient idea of demon-possession or the contemporary notion of the "disease of schizophrenia," have been recurrently attractive both to mental health professionals and to those who suffer from their own or others' madness. Especially as a corrective to the excesses of an era in which many professionals blamed parents for psychotic suffering, the idea of psychosis as a blameless disease process has brought to countless families a welcome relief from guilt and remorse. If your daughter has been felled by a brain disease, she does not have a more diffuse and complicated sickness of the soul, and you are not a soul murderer. In addition, categorical ways of framing schizophrenia have permitted some useful research into the etiolo-

gies of psychotic suffering and have facilitated the development of pharmacological treatments that have made decent lives possible for many who would once have been candidates for physical restraint, life-long hospitalization, or lobotomy.

But they have also constricted our therapeutic imaginations. Many in this audience may remember the person-on-the-street interviews in Daniel Mackler's (2008) touching documentary, "Take These Broken Wings," in which virtually every nonprofessional interviewee opines that schizophrenia is a brain disease, a neurotransmitter defect, a chemical imbalance that only the proper medications can correct. As I remember the professional atmosphere of my early training in psychotherapy, I can see how, shortly after the discovery that chlorprozamine could mute many psychotic symptoms, we began, with the best of intentions, to descend a slippery slope in how we talked with patients – and with the families of patients – who were diagnosed with schizophrenia. To promote compliance with the new antipsychotics, which seemed to offer so much hope for transforming so many lives, we began to engage in paternalistic oversimplifications and explanatory shortcuts.

The tendency to compare schizophrenic suffering to a chronic disease process caused by an ongoing neurotransmitter malfunction, and thus alleviated only by replacement pharmacology comparable to prescribing insulin for diabetes, began as a somewhat manipulative but perhaps forgivable stratagem that mental health professionals adopted to get at-risk patients to take their prescribed antipsychotic medication. Not surprisingly in the case of a lie that is repeated often enough, this story has, as George Orwell might have predicted, become the popular wisdom about the essential nature of madness. Professionals as well as lay people have bought into this narrative, with considerable help from pharmaceutical and insurance companies, who have much to gain in framing psychosis this way.

A glitch in the brain has no special meaning, can respond to no psychological intervention, involves only deficit, and offers nothing elevating or informative from which the patient and the rest of us can learn. This reductionistic formulation leaves no space for therapeutic identification and empathy, for the mutual exploration of subjectivity, or for the sense of competence that comes from a suffering person's intimate acquaintance with, and mastery over, his or her internal psychological saboteurs. I worry in these technocratic times that we are at risk of losing a fragile and vital piece of ancient wisdom; namely Terence's observation that, "Nothing human is alien to me."

Every age and every known society has had to face the challenge of trying to understand and deal with those we currently describe as mentally ill. In different historical eras and different cultures, responses to madness have been remarkable for their diversity – everything from torture and death to idealization and sainthood. Today I ask you to consider the proposition that the central challenge for our particular era and culture involves correcting the widespread consequences of accepting a categorical model in the absence of any dimensional sensibility. Subtly embedded in common phrases such as "the psychotic," "the schizophrenic," "the disease of schizophrenia," or "the person who has schizophrenia" is the insidious assumption that the best way to depict the process of losing one's mind is as a condition in which one is taken over by, and defined by, an invading otherness or a permanently deforming calamity. While it is intuitively resonant that losing one's sanity involves some strangely alien invasion and qualitative distortion of the mind that categorical formulations capture nicely, I suspect that the contemporary tendency to see madness only from this perspective can be as devastating to our progress in understanding and ameliorating psychotic suffering as it would be devastating to the development of quantum theory if physicists viewed certain phenomena as only particles or only waves.

I want to argue specifically that the disquieting idea that we all have the potential for madness offers a realistically based expansion of hope for the reduction of psychotic anguish and a corrective to an over-reified conception of extreme mental states. This is not, by the way, to insist that we are all potential candidates for the narrower diagnosis of schizophrenia. There is considerable

research suggesting that many of us simply lack the constitutional prerequisites for developing that version of psychotic psychology. But it is to say that any of us could go mad in the ancient sense of a serious loss of contact with conventional understandings of reality, and that we could all lose our moorings to such an extent that our lives are completely taken over by our craziest self-state (cf. Bollas, 2013).

Historical Background

Every age tends to overcorrect for the excesses of the previous era. Like generals trying to avoid the devastation of prior battles, we are always fighting the last war. The tired "nature-nurture" polarity that permeates discussions of psychosis tends to accompany the categorical versus dimensional tension, and here the ebb and flow of oversimplified emphasis on one, subsequently corrected by oversimplified emphasis on the other, is readily apparent; we tend to go through cycles of emphasizing nature at the expense of nurture and vice versa. In the mid-twentieth century, all sorts of psychological ills were attributed solely to nurture; contemporarily, they tend to be ascribed solely to nature, as some defenders of DSM-5 have made clear in announcing that all psychopathologies are disorders of the brain. (I have always appreciated Hebb's comment that arguing about nature versus nurture is a bit like arguing about what is the most important dimension of a football field: "length or width?" Epigenesis is vastly more complicated.)

The dimensional sensibility that I am urging therapists to reassert, a sensibility that characterized much of the mental health field throughout the middle decades of the twentieth century and that I believe represents the wisdom of many cultures and ages before our modern and postmodern eras, was itself, in the twentieth century, a corrective (and sometimes an overcorrective) for the Kraepelinian categorical diagnosis that had dominated the times in which Freud originally wrote. In fact, that either-or, present-versus-absent approach to conceptualizing and classifying psychopathology so dominated the late nineteenth-century psychiatric landscape that it took several decades of clinical practice for psychotherapists to overcome Kraepelin's once unchallenged presumption that neurosis and psychosis are discrete, non-overlapping categories.

First, the early modern practitioners slowly differentiated individuals with neurotic characters from those with simpler neuroses that seemed to result from a combination of stress and inner conflict in the absence of personality pathology. The concept of "character neurosis" or "character disorder" or, later, "personality disorder" became a kind of middle ground between neurosis and psychosis. Later, clinicians formulated the concept of a borderline area between neurosis and psychosis (a conceptualization that became concretized in 1980 in the DSM category of Borderline Personality Disorder). The shared inference that we are all more simply human than otherwise, as Sullivan memorably noted - that there is a range of severity of psychological suffering, in which "carving nature at the joints" is not so easy - thus grew out of a long, complicated clinical conversation.

Our contemporary taxonomies of psychotic disorders are rooted in late nineteenth-century psychiatric sensibilities that flourished in that era's idealization of reason and rationality. According to the categories of the Enlightenment era, what is pathognomonic of psychosis is the sufferer's loss of contact with reality. This focus on reason or its absence captured what was thought to be essential to know for diagnostic purposes: Even if someone's psychological problems were severe - as were, for example, those of the "hysterical" women described by Freud and Breuer, if the patient could appreciate what the surrounding culture deemed "reality," he or she had a neurosis. So even though Anna O. experienced self-states in which she had hallucinations and could not speak her native language, she was, on the basis of her capacity to reflect realistically on her experience, "a neurotic." If, however, the patient lost touch in major, ongoing ways with conventional definitions of reality, he or she had a psychosis.

At the end of the nineteenth century, the demarcated "functional" (as opposed to organic and toxic) psychoses were dementia praecox, later renamed schizophrenia (often divided into sub-

types such as simple, paranoid, hebephrenic, and catatonic), and the affective psychoses: psychotic mania, depression, and the extreme manic-depressive conditions that we now call Bipolar Disorder with psychosis. As the inheritor of that diagnostic sensibility, Freud was careful to insist that psychoanalysis, as he had developed the technique, was a treatment for neurosis but not psychosis. (He did believe, however, that some of the inferred psychological processes he had uncovered in neurotic patients could shed light on psychotic experience and eventually inspire therapies for the psychoses.) It fell to later theorists and therapists to develop ways of listening and talking therapeutically with people who suffered from the more psychotic versions of mental suffering. In the psychoanalytic community, this kind of healing relatedness was often referred to as supportive psychotherapy, as opposed to "exploratory" or "uncovering" therapy.

As psychotherapy developed as a profession, clinicians soon began reporting that the dichotomy between the sane and the crazy is not so simple. As mentioned, they began identifying a borderline range of psychopathology (e.g., Grinker, Werble & Drye, 1968). A profusion of articles appeared during the middle of the twentieth century on people whose intense, irrational, or maladaptive thoughts, feelings, and behaviors seemed reasonable to them (diagnostic suggestions included the "as-if personality," "ambulatory schizophrenia," the "psychotic character," "pseudoneurotic schizophrenia," the "borderland" between neurosis and psychosis, "borderline states," "borderline syndromes" and "borderline personality organization"). Because individuals who suffered in that limbo between neurotic and psychotic suffering lacked first-rank Schneiderian symptoms, they did not map easily on to the existing categorical notions of psychosis. But such patients were clearly more troubled than those with an anxiety attack or phobia or obsession or compulsion that could be identified as an intrusion on, and exception to, one's usual state of mind.

The first phenomenon that seems to have gotten the early analysts' attention, probably because it is so taxing to deal with therapeutically, was that patients in the borderline area between neurosis and psychosis tended to have what was labeled as "psychotic transferences." They felt not as if the therapist was like an important object of love or hate in their lives; instead, they were sure that the therapist was exactly like such a person. (Neurotic patients in in-depth analyses who entered the regressive state of a "transference neurosis" often found themselves with similar convictions, but usually after a long period in which they easily saw the "as if" quality of their transferences.) Clinical experience kept attesting to the impression that within every neurotic or even healthy person one could find, in Michael Eigen's memorable phrase (Eigen, 1986), a "psychotic core."

At the same time, therapists trying to learn how to be helpful to diagnosed psychotic patients were reporting that within every manifestly crazy person were areas of realistic – even remarkable - perceptiveness and adaptation. Because of these accumulating experiences from both ends of the spectrum of mental health, a dimensional sense of pathology and personality structure became the normative assumption in many clinical circles. For example, Kernberg's (1984) notion of "levels of severity," or the gradations of personality organization depicted in the Psychodynamic Diagnostic Manual (PDM Task Force, 2006), posit that within every kind of familiar symptom syndrome or psychic structure, there is a range of possibility for how crazy - or not - the sufferer is. At the more psychotic end of each spectrum, therapeutic approaches, emphases, and styles are required that differ substantially from those that help patients characterized by what has been variously called the therapeutic split in the ego (Sterba, 1934), the presence of an observing ego (Greenson, 1967), the attainment of object constancy (Mahler, 1972), or high ego-strength (Bellak, Hurvich & Gediman, 1973), or solid reality-testing (Kernberg, 1975), or self-cohesion (Kohut, 1984), or self-efficacy (Bandura, 1997) or the capacity for reflective functioning (Fonagy, Gergeley, Jurist & Target, 2002).

In the 1970s, many clinical writers (e.g., Masterson, 1976) implicitly equated levels of severity with fixation at normal developmental challenges. Neurotic-level patients were seen as coping with oedipal-level problems. By the time they reach the pre-school years that Freud called oedipal,

children have ordinarily become capable of appreciating that two other people can have motives that are not about them, and they can be aware of mixed feelings about that. In other words, the five-year-old child can appreciate others' separateness, can mentalize their possible individual intentions, and can reflect on his or her own conflicting internal responses (Fonagy, Gergely, Jurist & Target (2002). The adult neurotic patient has those capacities as well. Borderline-level patients were seen as stuck at Mahler's separation-individuation phase, in which intense dyadic relationships predominate; powerful all-or-nothing ego states are common; mentalization and reflective functioning are minimal; and closeness threatens engulfment, while distance threatens abandonment.

Psychotic-level patients were seen as having remained unconsciously preoccupied with the questions of earliest psychological life: Do I exist as a separate person? Am I safe or unsafe? Am I good or bad? In children in the first eighteen months of life, the phase that Peter Fonagy has called "psychic equivalence," the capacity to distinguish between what is internal and what is external is not yet fully established. It is to this mental uncertainty about inner versus outer that the person struggling with psychosis seems to regress under stress. The quality of the psychotic person's terror, confusion, and emotional intensity can indeed be as primitive and compelling as the naked anguish of a distressed infant. If one assumes that we all have the potential for collapsing into such states of mind, then there is nothing inherently devaluing about thinking of psychotic states as having some communalities with infantile experience.

I have argued, and seen myself as representing, most psychodynamically oriented diagnosticians in the position that in any type of personality, one finds some individuals who are psychologically healthy, some who are characterologically neurotic, some who have borderline personality structures, and some who inhabit an internal psychotically organized world, whether or not they have hallucinations and delusions (McWilliams, 2011). As the cognitive-behavioral orientation continues to develop its diagnostic language in the crucible of ongoing clinical experience, a similar dimensional sensibility is emerging from its practicing therapists (for example, I think that the writings of both Marsha Linehan (e.g., 1993) and Jeffrey Young (Young, Klosko & Weishaar, 2003) on borderline psychology imply this assumption).

The idea that psychosis reduces to the general cognitive problem of a loss of contact with reality, as exemplified by hallucinations and delusions, is, as it turns out, far too simple, as well as far too insensitive to the emotional aspect of psychotic suffering. Both diagnosably borderline people and healthier individuals under severe psychological stress may go temporarily out of their minds. Conversely, as we are increasingly learning, many people who hear voices or nurse ideas that the rest of us regard as deluded are frequently, by every other common-sense criterion of mental health, highly functional and competent in the world of consensual reality (see, e.g., Williams, 2012). The sense that there is a spectrum of potential difficulty, that people's developmental challenges have made them differentially vulnerable to varying reactions to life's shocks and ordeals, and that under enough stress, any of us could regress to psychotic ways of thinking and feeling was for many decades an article of faith in the experienced practitioner community, especially among those therapists who worked with the most troubled clients.

But official wisdom changed with the 1980 DSM-III decision to describe all problems in an exclusively neo-Kraepelinian, categorical way. As I understand it, this decision was made mainly because such a paradigm reversion would facilitate certain kinds of empirical research. The clearest exemplar of the U-turn toward a predominantly categorical diagnostic classification, in preference to the inferential, biopsychosocial combination of categorical and dimensional sensibilities that had come to represent clinical knowledge, was the decision of the DSM-III Personality Disorders task force to depict "Borderline Personality Disorder" as a type rather than a level of personality organization. In a stunningly arbitrary dismissal of the accumulated observations of practicing therapists, about which many complained at the time (see, e.g., Klerman, Vaillant, Spitzer & Michels,

1984), a categorical concept displaced the idea of a spectrum that we had for decades seen as the best interpretation of the complex clinical data. There are some good, research-oriented reasons to frame borderline psychopathology categorically, but for purposes of clinical understanding and treatment, many seasoned therapists have lamented this choice (see, e.g., PDM Task Force, 2006).

The 1980 tour de force ushered in such a naively positivistic mindset that now, after more than three decades of thinking that borderline psychopathology is a measurable, present-versus-absent thing, the DSM-5 has even dispensed with the caveats prominently featured in prior editions of the manual, which reminded readers that its classification system was not a substitute for more nuanced clinical judgment. Currently, we therapists are being urged to restrict our work to so-called "evidence-based treatments" that have been found by researchers, usually in highly artificial settings, to reduce the observable symptoms of each categorical DSM disorder. The latest DSM seems to accept, perhaps even smugly, its frightening designation as the "Bible" of the mental health community – the revealed truth of the faithful.

Arguably more than any other single decision in the neo-Kraepelinian revolution, the rejection of naturalistic observation and clinical reflection epitomized in establishing the category now known as "BPD" has undermined the older understanding that any of us can look borderline under enough stress, and that the boundary on both the psychotic and neurotic sides of the borderline territory is quite permeable. Of more dire import for ISPS members, the isolation of psychotic conditions as qualitatively different from other kinds of mental suffering has been fully achieved with the destruction of the assumed continuum from mentally healthy through neurotic, through borderline, to a general psychotic area we could all recognize as a universal human possibility.

Interestingly, the DSM paradigm shift was not entirely successful in omitting all assumptions of a spectrum. Because reified categories are not a good representation of the range and complexity of human mental suffering, dimensionality crept back in in several places. For example, according to Roger Greenberg (personal communication, Sept. 28, 2006), the reason we have the category of schizoaffective psychosis is that British and American psychiatrists were in the habit of diagnosing certain affectively infused psychotic presentations differently, the British as manic-depressive, and the Americans as schizophrenic. When they could not agree, they solved their political problem by inventing a diagnosis that could characterize psychotic states mid-way between the manifest affective flatness of schizophrenia and the emotional intensity of those in bipolar psychotic states. Thus, an implicit continuum of phenomenological emotionality was established.

Aspects of Psychotic Experience

What elements besides a "break with reality" have experienced therapists come to understand as characteristic of psychosis? From a cognitive perspective, irrational beliefs are certainly a central part of the story. Therapists from several contemporary theoretical orientations continue to work on developing ways of addressing delusions therapeutically, tapping the capacities of diagnosed psychotic patients to rethink their most self-damaging but cherished convictions. I do not want to minimize the importance of the cognitive aspect of going mad, but I think there are other elements of the overall psychotic picture that are equally important.

As I have noted, from a psychoanalytic developmental standpoint, the hallmark of psychotic experience is an inability to discriminate what is inside from what is outside. A psychological merger with others dominates experience, and because a continuous and reasonably valued sense of a separate self has somehow not been fully achieved, annihilation anxiety is pervasive. Developmentally archaic defense mechanisms, including splitting, projective identification, denial, withdrawal, omnipotent control, dissociation, and primitive versions of idealization and devaluation deploy automatically and to the great overall detriment of the patient and others.

From an emotion-focused perspective, the inability to tolerate and regulate overwhelming affect is centrally implicated in psychotic decompensation. The interpersonal withdrawal and affective

flatness of some diagnosed schizophrenic patients may be partly understandable from that angle of vision; in other words, their flatness is a defense against being inundated with unendurable feelings. Patients in the catatonic conditions that were common before the antipsychotics tended to describe their experience, when the catatonia remitted, as an unbearable excess of affect, not an absence of emotionality. The terror in psychotic suffering is excruciating. One of my more schizoid friends describes himself as having to manage "proto-affect," in which he feels himself at risk of drowning in the intensity and complexity of his emotional response. Although he has never become diagnosably psychotic and is well past the usual age for an initial descent into a condition describable as schizophrenic, he regards losing his sanity as a painfully ongoing possibility.

From a phenomenological perspective, what distinguishes psychotic-level pathology from less grave problems is the elevation of a specific, uncontainable preoccupation over everything else in the person's life. This aspect is worth emphasizing, as it is insufficiently emphasized in our taxonomies and textbooks. Michael Garrett (personal communication, March 30, 2013) has described the functioning of those at the psychotic end of the spectrum as like a "recurrent opera with only two or three characters" – so consuming is the person's psychotic narrative that his or her whole life has been reduced to the delusional story. We have all seen how the shrinking, consuming preoccupations of individuals who are becoming increasingly psychotic can exhaust and destroy the social fabric that could support them. When this happens, the self-conceptualization of "mental patient" can override all prior identities, forever trapping the patient in a dead zone, the ghost of a person who might have been.

In terms of their subjective experience, we know that people in psychotic states feel overwhelmed by stimuli that crowd in on them and penetrate their consciousness against their will, making it impossible for them to discriminate self from other, figure from ground. They suffer from intolerable, unstoppable impingement by sense impressions that they cannot sort out. They become frighteningly stimulus-bound (Piaget, 1954). As Louis Sass (1992) has emphasized, they are taken over by what has been felicitously called hyperreflexivity as they try to retreat from the cacophony of unrelenting assault by one sensory impression after another. The improvement that the antipsychotic drugs provide, as medicated patients describe it (Mizurahi, Bagby, Zapursky & Kapur, 2005), seems to involve a kind of deadening of the intensity of those stimuli, not a qualitative change in their symptoms.

Dimensionality in Psychopathology

One of the casualties of the current descriptive, categorical diagnostic systems that drive most mental health policy, whether the ICD or the DSM, is the time-honored clinical conclusion that there is a psychotic level or version of most clinical syndromes. Why we have decided that schizophrenia and psychotic mood disorders, along with the conditions we used to call toxic and organic psychoses, exhaust the possible ways to go crazy is a mystery to me. Let me give you some examples of other conditions that I think could be considered just as insane as the delusional world of the person with a manic or depressive or schizophrenic or schizoaffective psychosis, as conventionally diagnosed.

We have all seen clients who are so severely obsessional that even though they do not report hallucinations, their ruminations are pretty deluded. For example, they may sincerely believe that if they do not carry out their rituals, some disaster will befall them. They do not simply worry that this could happen, they know it. They know it so confidently that they cannot abandon their rituals in order to test their convictions, because if they even think about doing so, they become overwhelmed with what therapists have long referred to as psychotic or paranoid or annihilation anxiety (Hurvich, 2003) – in contemporary terms, what Jaak Panksepp (Panksepp & Biven, 2012) would see as the activation of the FEAR system, the evolutionary legacy of our terror of being destroyed by predators.

One of my obsessional patients, a woman who has never been dramatically ill enough to be de-

scribable as having had a psychotic "break," accounted for her tardiness to a session by explaining that she had gotten a late start boiling her sheets and towels. "You boil your sheets and towels?" I asked. She responded with irritated condescension that of course she did so, daily. If she were to neglect this aspect of ordinary hygiene, her family could get some dire illness. In response to the hint in my question that her fastidiousness might be excessive, she was not able to reconsider her belief; instead, she seemed to conclude that she could not trust a therapist who was so frighteningly naïve about the constant dangers posed by germs. She began to treat me warily, despite several years of our warm collaboration, as if I were now reduced to being a source of contamination. How is this any less crazy than the person who hears voices?

One of my severely hypochondriacal clients oscillated between intense worries about her health and full-blown somatic delusions. When she was most upset, she would talk about her body as if it were a persecutory alien object conspiring to torment her, and she had strange ideas about her own anatomy that could have come out of a medieval treatise on the physiognomy of witches. She does not sound particularly crazy unless she is talking about her physical condition, but when that is the topic, and it is often difficult for her to spend much time talking about any other topic, she sounds utterly deluded.

A paranoid client of mine who has never had a classic psychotic episode suffers periods of such devastating anxiety that he goes days without sleeping. When he does manage to drop off, he startles awake in a state of panicky conviction that without his wakeful hypervigilance he is in mortal danger. His dreams are full of humiliation, torment, and attack, all aimed at him, all the expectable consequences of his having had the gall to take up any space in the world or embrace any hope or accomplish anything successful. Conversely, one man I treated for a few months who had had a severe psychosis in his first year at college, who heard voices that convinced him he was the resurrected Jesus, recovered fully with intensive support at the time of his first break – most notably from a psychiatrist who talked his family into keeping him out of the hospital and who saw him every day for weeks during the reign of his delusion. He has lived a generative, rich life ever since that crisis. I think of the second man as better off psychologically than the first, and yet the second is the one who has carried the psychotic label.

Those of us who work with individuals with eating disorders are familiar with the phenomenon of the severely anorexic patient who weighs so little that her life is at risk but who believes she is grotesquely fat. The reality of her being in grave physical danger is completely eclipsed by her psychological conviction that she is obese. Most mental health professionals have no trouble believing that psychotherapy is valuable for extremely difficult eating-disordered patients like her, who are surely as crazy and self-destructive in their way as are many people who hear voices. What is it about the official categories of psychotic disorders that impel most of the world to assume there is a qualitative difference between the delusion of a starving woman that she is overweight and the delusion of the wretched sinner that she is the Virgin Mary?

There is a small community of men with sexual paraphilias who have their healthy limbs amputated and then circulate photos of their maimed bodies on the Internet in search of lovers. They feel much more attractive as amputees than they did when their bodies were whole, and they find others who mirror that view. Individuals with Munchausen's syndrome will undergo needless surgeries, or deliberately harm themselves or others, evidently out of some crazy conviction that the recurrent enactment of a life-and-death drama is the best route to connection and meaning in their lives. More prosaically, an agoraphobic neighbor of mine has not left her house for over twenty years. Despite her lip-service to the irrationality of clinging to hearth and home as if one step into the outer world would destroy her, she is too overwhelmed by terror to venture past her front door.

Some survivors of trauma regularly experience what analysts have called psychotic or traumatic transferences (Kluft, 1992): flashback-like experiences in which others, and sometimes the the-

rapist, are felt to be dangerous persecutors like their original molesters and torturers. They may experience such reactions not with the self-reflecting attitude of the person who notices that it is as if the clinician has become like the abuser, but with deep conviction that "it is all happening again." We know that severe trauma can precipitate psychosis, but even the stress of trying to trust a stranger who calls herself a therapist can provoke a post-traumatic, flashback-like transference. How do we not see such experiences as psychotic phenomena?

Some antisocial individuals who maintain their equilibrium and support their self-esteem by manipulating others seem, to most intents and purposes, to live in a similar assumptional world as the rest of us, even if they believe the rules shouldn't apply to them. Others, the ones Henderson (1939) called aggressive/violent psychopaths, may plot murder after murder in a crazy, ritualized, sexualized effort to feel safe, powerful, and alive, often targeting victims of a particular physical appearance or socioeconomic status that would prompt a psychoanalytically inclined observer to wonder about the psychotic intent to destroy the internal bad mother. I appreciate that our legal categories make it impossible for forensic purposes to argue that some psychopathic individuals are also insane – in fact, many legal decisions hinge on the categorical, either-or question of whether a given perpetrator is psychotic or psychopathic - but surely in every ordinary meaning of the term, some sadistic murders are both.

Eric Marcus (2003) writes about "near-psychosis" in a range of people who are otherwise free of mental illness, like the mostly asymptomatic friend of mine who opened the refrigerator on the anniversary of her beloved grandmother's death and, in a transient hallucinatory state, saw the grandmother inside. Sometimes such phenomena suggest that a psychosis could easily be precipitated; at other times, they seem to be of no more import than any other eccentricity a person might have. The contemporary practice of checking off the relevant DSM criterion for psychosis when a patient "endorses" a question about hearing voices is often executed irrespective of whether the voices are telling the patient to kill her daughter or reminding her to take her vitamins. I have been shocked in recent years to learn how many young therapists are not trained to ask about the content and context of the answers to their diagnostic queries.

I would guess that most of the clinicians in this room can think of fragile patients who would have had a psychotic break in the absence of psychotherapy or organized social support. Unfortunately, like the politician who cannot prove that his pet policy has prevented the mayhem that would have happened in its absence, we cannot prove that we have accomplished this prophylaxis; effective prevention is hard to demonstrate empirically. (Even cure is hard to demonstrate empirically when the prevailing response to the dramatic improvement of a person diagnosed with schizophrenia, especially if it occurred without antipsychotic medication, is the defensive assumption that he or she was obviously not schizophrenic in the first place.)

My colleague Richard Reichbart recently disclosed at a meeting of the APA Division of Psychoanalysis (2012) that he had had a disabling, florid psychotic break as a young man. No one who had known him over his distinguished career as a therapist and teacher would have suspected this. Audience members were not surprised, however, to learn that his recovery involved the devoted, daily care of a fine clinician, a man unafraid to work in depth with a severely disturbed patient. Richard has been free of psychotic symptoms for over thirty years. Similarly, Elyn Saks (2008) has inspired us with her account of madness and healing. Even though she still takes medication to calm her voices, she surely is a poster child for a kind of mental health. As is Joanne Greenberg, who never took antipsychotics but trusted in the big heart of Frieda Fromm-Reichmann. And countless others known to this audience, who are arguably a lot more sane in any ordinary meaning of the term than many non-psychotic people we all know.

What Is To Be Done?

If psychotherapy is a useful response to the suffering of the deludedly anorexic, the deludedly obsessional, the deludedly phobic, and others, why have we minimized its value to individuals

struggling in psychotic territory? Not because therapy is qualitatively more difficult with the people we diagnose as schizophrenic or schizoaffective or psychotically bipolar, because it is arguably just as difficult with individuals of these other descriptions. And not even entirely because of contemporary, myopic efforts at cost-containment, which plague us all despite the increasing empirical documentation of the fact that with a longer-term view, to quote Susan Lazar's (2010) title, psychotherapy is worth it. I think part of the answer is that to get our nations and communities to support the treatment to which our psychotic patients are entitled as fellow human animals would require a paradigm shift in our habits of thought. And that shift depends on a victory over a pervasive denial about the nature of the human condition.

I am thus arguing for a correction to the course that has been charted by an uncritical acceptance of neo-Kraepelinian categorical thinking. Perhaps a shared effort is called for to retain a dimensional appreciation of the range of human suffering and the empathy that such a sensibility encourages. When colonizers want to subdue an indigenous population, the first thing they do – not necessarily with conscious intent – is to marginalize and destroy the common language of the people they are subjugating. The language that has evolved from clinical experience with patients diagnosed with psychotic syndromes is currently being replaced by the language of corporate bureaucrats, pharmaceutical marketers, and policy wonks, who are eager to reference only the "evidence" provided by academic researchers using short-term symptom relief as their major criterion of improvement, many of whom have very little experience in the clinical trenches and certainly not enough grant money to do the long-term follow-ups that the evaluation of psychotherapy with the seriously mentally ill would require.

With respect to contemporary resistance to embracing the full humanity of those we have classified as psychotic, I think Bertram Karon (1992) has captured much of problem in his classic article on the fear of understanding schizophrenia:

- It is generally believed that a treatment that is more effective will be used, but
- psychological treatments for schizophrenia and other psychotic reactions have been
- avoided despite the evidence for their effectiveness from the time of "moral treatment" to
- the present. Less effective (or even destructive) treatments have been seized upon, in part
- because they do not require understanding of these patients, understanding schizophrenic
- persons means facint facts about ourselves, our families, and our society that we do not
- want to know, or to know again. (p. 191)

Central to the denial that supports the artificial segregation and "othering" of people with categorical psychotic diagnoses is our reluctance to acknowledge our own vulnerability.

Western literature is replete with portraits of individuals driven mad by the sheer unbearableness of their lives, and nonprofessional readers have for generations identified more compassionately with that fate as a universal peril than most twenty-first century scientists are willing to do. One thinks of Lady McBeth, hallucinating in her agonizing guilt; Dickens's Estelle Haversham, traumatized by disappointment and delusionally fixated on the day of her wedding; Hemingway's short story, "A Way You'll Never Be," recounting a soldier's hallucinations and delusions in the aftermath of battlefield terror. Our great writers are capturing something that goes way beyond a discrete dopamine malfunction to the dangers we all face as we suffer and love and strive and fear.

Taking a stance that challenges conventional wisdom and the perquisites of the powerful inevitably risks the ancient fate of Cassandra, a woman cursed with the gift of prophecy and doomed not to be believed. Robert Whittaker is perhaps the best exemplar of a contemporary Cassandra. A friend of mine who has worked therapeutically with diagnosed psychotic patients in a hospital setting for several decades recently hosted an eminent, biologically oriented psychiatrist at a gathering for residents at his medical center. On learning that Whittaker had been invited to address the same group, the guest launched gratuitously into a tirade, the point of which seemed to be that Whittaker is beyond the pale of mainstream psychiatry, which understands that trea-

ting people's potential psychiatric conditions with even earlier drug interventions is the wave of the future: Onward and upward to pharmaceutical utopia.

A few minutes later, this critic was noting that, of course, a down-side of the current enthusiasm for medicating inconvenient behavior might be the overprescription of powerful psychoactive drugs for children – one of Whittaker's main points. Evidently when trying to speak truth to power, we have to tolerate being the target of dripping contempt, and worse, we have to tolerate the likelihood that we will never be officially vindicated, even if - perhaps especially if – our message is actually getting through.

Speaking of Cassandras, my friend George Atwood (2011) offers the following "definitive theory of depression" in his wonderfully polemical book, The Abyss of Madness: "It is caused by the depressing things that happen to us" (p. 162-163.). Or as my colleague Tom Tudor has memorably put it, "Bad things happen and they screw you up." To believe that life could make any of us crazy with grief or terror or confusion or emotional exhaustion is not incompatible with acknowledging that we as individuals are differently subject to depressive reactions, have different biologically based vulnerabilities, and differ wildly in what kinds of experience set off the pathological reaction.

The categorical-dimensional paradox

Finally, let me return to recommending that we hold the paradox, as Winnicott would say, of a coexistence of dimensional and categorical ways of thinking. A qualitative sense of difference can be useful; I would not want to overcorrect contemporary Kraepelinians by insisting on a simply dimensional formulation of psychosis. Knowing that there is something different about someone in a psychotic state can prevent us from failures like those of some earlier psychoanalysts, who treated people with schizophrenic symptoms as if, because we are all on the human continuum, one kind of therapeutic technique should apply to everyone. A categorical sensibility can make us curious about what we cannot understand by identification, and encourage us to get our patients to educate us. It can alert us to the potentially life-saving nonverbal message that "something here is way out of kilter."

Let me emphasize that this openness to the value of a sense of categorical difference does not equate to a position on the biological-versus-psychological-etiology question. There seem to be many routes to becoming diagnosably schizophrenic, some involving more genetic tilt and some involving more disabling experience. And it is falsely reductionistic and naïvely Cartesian to assume that psychologically based problems require psychological solutions, whereas biologically based problems require biological ones. Biological events affect psychological experience, and psychological experience affects biology. Pharmaceutical intervention can reduce psychotic misery, and psychotherapy can change the brain.

Everything in the body can break; surely the brain can break. It would be interesting, if we could get a better understanding of the complexities of etiology, to do clinically informed research on whether individuals whose psychotic symptoms have more of a biological origin are the hardest to engage in a healing relationship. But even people with broken brains have souls. If our common language tends to reduce a psychotic person to a malfunctioning brain, we have killed the psyche and are engaged in soul murder on a truly monumental scale.

Concluding comments

Today I have emphasized dimensionality not simply to remind us of our common humanity - a lesson that this group does not need to learn - but to point out that how we officially label and conceptualize psychotic suffering has massive social consequences. We cannot avoid the fact that our ideas about mental health and illness are socially constructed. What seems obvious to us in this era and culture may look bizarre to our descendants. But we need to keep exposing the limitations of the prevailing diagnostic paradigms as one way of trying to counteract the oversimplified "othering" that has come to characterize our implicit cultural attitudes toward those of our fellow creatures who are most in need of our empathy and respect.

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L 115
Psychoanalytic psychotherapy of psychoses and dramatology.

Henry Zvi Lothane
MD

Action and interaction, emotion and feeling, thought and language play a central role in the lives of individuals, families, and society, spanning the continuum between everyday life and disorder. Heretofore narratology has been the main medium for portraying action and interaction and little was written about the dramatic approach to life, disorder, and therapy. Since lived life is primarily drama: action and interaction, intention and influence, events and encounters, the author has proposed the method of dramatology, a new emphasis and synthesis, to complete narratology. Dramatic encounters are the primary facts of life secondarily convertible into first person or third person narratives. While a story describes, drama enacts. The center of drama is direct communication and expression of emotion: through body gesture and face, and with the spoken word. Dramatology is in consensus with the psychosocial approach to psychosis: it explicates the dramatic nature of such psychological formations of psychosis as delusion and hallucination. Dramatology also spells out the dramatic aspects of psychotherapy of the psychoses. Central in Freud's dynamic method were dramatization in fantasy: the ability to experience images in dreams, daydreams, hallucinations; and dramatization in act, the ability to act out, to enact communications in body gesture and facial expression and in emotions. The author suggests that what Freud called psychic reality should be renamed emotional reality. The traditional conceptions of psychosis have been monadic, as in the systems of Kraepelin or Jaspers. In contrast, Sullivan established a dyadic and interpersonal approach to psychosis. The goal of dramatology is to promote an interpersonal psychiatry and an interpersonal psychoanalysis.
Psychiatry has lost its psyche or soul, instead it acquired brain. Or you might say it lost its mind, a kind of schizophrenia. Psychoanalysis has lost its body and split into many schools, another kind of schizophrenia. Since the word psychiatry means healing the soul, we ask: is there still hope for the soul in the age of the brain, especially as far as the psychoses are concerned? While the brain can be seen as an organ, under the microscope, or in an fMRI but the soul cannot: thus calling the healing method psychotherapy begs the question: what is it empirically, how is it defined operationally? Its proper operational name should be talk therapy, the talking cure as of Anna O.,

the founding patient of psychoanalysis and its co-inventor said to her therapist Breuer, or word therapy, as suggested by the great historian of medicine Pedro Lain Entralgo. The talking cure is a conversation, a dialogue between a patient and a therapist, defined by their roles and rules of the game.

Freud on the methodology of psychotherapy

In 1883 Freud worked for five months in Vienna's Allgemeines Krankenhaus on the psychiatric service of Theodor Meynert, a brilliant neuroanatomist and psychologist, his first encounter with psychiatric patients. That year he also heard from his scientific colleague Josef Breuer about his treatment of the famous Anna O. who suffered from a "psychosis of a peculiar kind." In 1885 Freud was at the Salpetriere with Jean Martin Charcot observing hysterics. Upon his return to Vienna Freud started a private practice seeing patients with nervous or hysterical complaints, the latter his chief interest. In 1888 Freud translated Hippolyte Bernheim's De la suggestion et ses applications a la therapeutique as suggestion and its therapeutic effectiveness and a year later visited him in Nancy. At some point in the 1890's he was inspired to publish a remarkable and largely unnoticed paper entitled "Psychische Behandlung (Seelenbehandlung)," psychical or soul treatment":

a therapy of disorders of body and mind with means, i.e., measures (Mitteln) that operate from the start and directly upon the person's psychological being (das Seelische). Such a measure is first and foremost the word, and words are the most important tools of psychical treatment (283). The "magic" of the word comes from words being the most important means of the influence that a person can bring on another. Words are a good method of producing emotional changes in the person to whom they are addressed (p. 292).

From the start, Freud established influence and interaction as superordinate dynamic factors in the effectiveness of therapy. He had two major interests: how therapy works and what disorders it can cure. A theory of disorder may either be empirical or speculative. A theory of therapy must be empirical. There is also an expectation that there should be a consonance between the nature of the disorder and the method to treat it.

Freud observed that disorders of body and mind are caused or aggravated by "violent affects, such as a severe shock of sudden bereavement, the influence of fear, rage, of psychic pain and of sexual delight, of persistent affective states of distressing or depressive states, such as sorrow, worry or grief, deep humiliation or disgrace, or even the unexpected impact of great joy." These states are seen in "functional [psychosomatic] illness, in neurasthenia or hysteria, obsessions, and delusional insanity." The actualize as 'expressions of the emotions' (Ausdruck der Gemütsbewegungen). A person's states of mind are manifested in tensions and relaxations of facial muscles, the expression of his eyes, in the amount of blood in the vessels of the skin, in the modifications of his vocal apparatus, and in the movements of his limbs and in particular of his hands. There can be no doubt that the duration of life can be appreciably shortened by violent affects such as the severe shock of sudden bereavement, under the influence of fear, of rage, of psychic pain and sexual delight, persistent distressing or depressive sorrow, worry, grief, shock, or humiliation. All psychical states, including those that we usually regard as 'processes of thought' are to some degree affective and not one of them is without its bodily expression. Even when a person is quietly engaged in a string of ideas, or images, there is constant series of excitations in smooth and striated muscles.

It is important to emphasize the difference between feelings, the awareness of the feeling tone, inseparable from all personal experiencing of the world, ourselves and others, and emotions, feeling-driven self-directed or other-directed actions, behaviors, conducts. Two of the most powerful personal actions-emotions are love and hate. I am pleading for acknowledging the paramount role of emotional reality as the source of thinking, dreaming and desiring. The mention of emotional shock foreshadows the theory of traumatic disorders. The emotional nature of a person's

disorder required a corresponding emotion-orientated approach to treatment in the therapist:
All the mental influences which have proved effective in curing illnesses have something incalculable about them, such as affects, the utilization of the will, distraction of attention, fostering expectations colored by faith (292). The doctor uses his personality to gain the patient's confidence and to some degree his affection."
The approach described in the above passage is hypnotic suggestion. For the therapist, the word becomes the tool of suggestion, by means of which "the idea which the hypnotist gives to the hypnotized by his word, he talks the person into hypnosis," a peculiar mental state, "in no sense a sleep like our nocturnal sleep or like the sleep produced by drugs" (295), but a dream state in which the hypnotized person is obedient and credulous in relation to the hypnotist, the idea given to the hypnotized by the word, by its magic, e.g., the suggestion of seeing a snake. The hypnotized sees and hears the way we see and hear in dreams, e.g., he hallucinates, because credulous like a child towards his beloved parents.
And this is why hypnosis works:
Outside hypnosis and in real life, credulity such as the hypnotized has to hypnotist is shown only by a child towards his beloved parents, and that an attitude of similar subjection on the part of one person towards another has only one parallel, though a complete one—namely a certain love relationships where there is extreme devotion. A combination of exclusive attachment and credulous obedience is in general among the characteristics of loving (296).
In the 1995 Studies on Hysteria Freud will call this affection Sympathie, sympathy, in German a synonym for love. In 1906 he would write to Jung: "Essentially the cure is effected by love."
In his first published case in 1892 of a cure by "hypnotic suggestion" of a young woman unable to breast feed her firstborn, whom he diagnosed as a hysterique d'occasion, Freud added self- or autosuggestion as the cause of disorder. In the wake of the "shock" of childbirth, and the fears it aroused" the patient, through "self-influence (auto-suggestion)," went into a state of "counter-will," causing her to stop nursing. Freud cured her by making "use of suggestion to contradict all the young mother's fears and the feelings on which those fears were based: Have no fear! You will make an excellent nurse and the baby will thrive." The drama had a happy ending and suggestion was here to stay but the puzzle of hysteria was yet to be solved.
Subsequently Freud reaffirmed the role of words in psychotherapy again in 1916: "nothing takes place in a psycho-analytic treatment but an interchange (Austausch) of words between the patient and the analyst. The patient talks and tells about his past experiences and present impressions, complains, confesses to his wishes and emotional impulses. The doctor listens, directs the patient's processes of thought, exhorts, gives him explanations." In 1921 he wrote: "in the individual mental life someone else is invariably involved, as model, an object, as a helper or an opponent; and so from the very first individual psychology is at the same time social psychology as well" (SE 18). In that work he revisited suggestion and connected it with primitive induction of emotion, imitation, and emotional contagion, all interpersonal phenomena. In 1933 he concluded: "Strictly speaking there are only two sciences: psychology, pure and applied, and natural science. For sociology, too, dealing as it does with the behavior of people in society cannot be anything but applied psychology." In life and disorder words were carriers of emotions and ideas between persons and cause psychic pain, i.e., trauma.
The trauma model of neuroses and psychoses Freud's next methodological step was to solve the mystery of hysteria. For 2,500 years the myth that the womb, hystera, wandered around in the body causing the disease hysteria ruled medicine even though Hippocrates only used the adjective, histerike. Down the centuries hysteria was used as a shorthand for the protean imitations (from the Greek God Proteus, a god fabled to assume many shapes) of organic diseases by people called hysterics who wandered from doctor to doctor with their imaginary diseases à la Baron Munchhausen. Rehabilitated by Charcot, such patients found sympathy and understanding with

Breuer and Freud. In 1893, combining the lessons of Anna O., the psychological mesmerists, and the studies of Charcot, Janet, and Bernheim, they published "On the psychical mechanism of hysterical phenomena," the introductory chapter of their 1895 Studies on Hysteria.
The authors observed that analogously to trauma caused by physical injury, for hysterical symptoms the precipitating cause is psychic trauma, any experience (Erlebnis) which calls up distressing affects—such as those of fright, anxiety, shame or psychical pain—depending on the susceptibility of the person affected; or, instead of a single, major trauma, we find a number of partial traumas forming a group of provoking causes able to exercise a traumatic effect by summation (6).
The crucial word is Erlebnis, which is broader in German, meaning a direct participation in an event, a significant occurrence in one's, a scene witnessed, an adventure or misadventure. Since psychic trauma is an interpersonal event, it follows that such an existential trauma is ipso facto a life drama. They also noted that "quite frequently it is some event in childhood that sets up a more or less severe symptom which persists during the years that follow" (4), i.e., dramas of childhood.
At this stage Freud is concerned with events and emotions and the genesis of disorder in an interpersonal encounter, as described in the vignette about the only man in the Studies on Hysteria:
A male employee who had become a hysteric as a result of being ill-treated by his superior suffered from attacks in which he collapsed and fell into a frenzy of rage but without uttering a word. Under hypnosis he revealed that he was living through the scene in which his employer had insulted him in the street and hit him with a stick.
The authors concluded that hysterics suffer mainly from reminiscences because memory of the trauma persisted. Breuer called his therapy of recollecting the initial traumatic-dramatic scene "with hallucinatory clarity" and with full expression of emotion the cathartic method, borrowed from the Aristotelian drama theory of catharsis, literally purging the bowels, figuratively purging the strangulated emotions. "In the conception of Plato and Aristotle katharsis is a psychagogic operation producing sophrosyne (temperance) by the employment of appropriate words" (Entralgo, 53). Cathartic therapy revealed the unconscious connections between reminiscences and past traumatic events. This therapeutic solution resulted in the dissolution, or removal, of the post-traumatic sequelae.
Breuer's patient Anna O., traumatized by the long illness and death of her father, "embellished her life by indulging in systematic day-dreaming, which she described as her 'private theatre', hallucinating terrifying images of skulls and skeletons. As she lived through these things, she dramatized them partially by talking." Thus Anna O. dramatized in two ways, in dreams and in deeds, in fantasy and in act. The word 'dramatized' was lost in Strachey's translation. Breuer's obsolete word for dramatizing was tragieren, acting in tragic drama. Freud would recapture this idea as agieren, acting out instead of talking it out.
In 1896 Freud published his analysis of Frau P., "32 year of age, married for 3 years and mother of a child of two. Six months after the birth of her child she became uncommunicative and distrustful, showed aversion to relating to her husband's brothers and sisters. After a quarrel between her husband and her brother she became depressed, experiencing delusions of reference and observation and hallucinating images bodies of naked women, felt as "physical sensations in her abdomen" and derogatory voices. Freud applied "Breuer's method, exactly as in a case of hysteria, for the investigation and removal of the hallucinations, on the assumption that in paranoia, just as in the two other defense neuroses, there must be unconscious thoughts and repressed memories." Freud analyzed the voices as "thoughts that were being 'said aloud', this being "a strange mode of expression and unusual forms of speech as traces of distortion through compromise." He viewed the derogatory voices the patient as heard as self-reproaches" as a defense "in a manner which may be described as a projection," the first published use of this term. Freud then traced these self-reproaches to "experiences analogous to her childhood trauma," "a series of scenes going back to from her seventeenth to her eighth or sixth year, of her brother and sister had for years

been in the habit of showing themselves to one another naked before going to bed." In 1907 Jung commented on this analysis as follows: "In 1896 Freud analyzed a paranoid condition and showed how the symptoms were accurately determined by the transformation mechanism of hysteria; that paranoia, just like hysteria and obsessions, originates from the repression of painful memories, and that the form of the symptoms is determined by the content of the repression." The childhood trauma was a drama, and so was the woman's illness, related to current family dramas and also intensified by reading Otto Ludwig's novel Die Heitheretei und ihr Widerspiel, with whose heroine the woman strongly identified.

Dramatization in images is the most important feature not only of hallucinating but also of dreaming while asleep and daydreaming while awake.

The dream model of neuroses and psychoses Freud's final evolution as psychotherapist was to replace hypnosis with free association, the authentic method of interpreting dreams, neuroses and psychoses, in his epochal Interpretation of Dreams: „though the subject of dreams was determined by my previous work on the psychology of neuroses, I should [have pursued] the contrary direction, dreams as a means of approach to the psychology of the neuroses" (588). Memory plays a role in both dreams and neuroses and both have a homologous dual structure. Dreams have a (1) a conscious manifest content, puzzling and strange, represented or dramatized in images, i.e., pictorial thought, scenes, sometimes with bizarre words and speeches, accompanied by emotions, in addition to dramatization, shaped by displacement and condensation; and a (2) latent unconscious content, the day residue, discovered by free association and expressed in straightforward prose, detailing the dramatic-traumatic life events and emotions that preceded the dream and instigated it. The transformative dynamics of the dream, the dream work (Traumarbeit), are paralleled by delusion-work (Wahnarbeit) and hallucination-work Both the manifest neurosis and the manifest dream are caused by recent trauma of life and by remote trauma of childhood; in both the manifest content is a transformation, or a translation, of the language of everyday life into the language of fantasy and fulfillment of wishes as compensation for conflict and emotional pain; both are a historical record of a life, both decodable by overcoming resistance, free association, and interpretation. Similar dynamisms operate in poetic figurative language of metaphor, allegory, and simile. The neurotic and the psychotic are native poets. They also use humor, play games, pranks, and tricks.

The dreamer, hallucinator and the delusionist were seen in a similar light. Freud cited Kant who said that "the madman is a waking dreamer;" Schopenhauer who "called dream a brief madness a long dream," and a mid-19 century soul psychiatrist A. Krauss: "Insanity is a dream dreamt while the senses are awake." However, in the last quarter of the century, brain psychiatrists erroneously equated dreaming with sense perception and defined hallucinating negatively, as pathological perception of nonexistent object instead of positively, as a sui generis psychic activity, as I showed in my 1982 paper: "The psychopathology of hallucinations—a methodological analysis." My illustrious compatriot Gustaw Bychowski wrote in his 1923 book Metapysics and Schizoprhenia which I recently discovered: "There is a barrier between imaging and perceiving through the senses, the difference between them is not a matter of degree. The most intense image does not possess the objectivity of a perception, the weakest perception cannot become a subjective image. In dreams, in which we withdraw from the real world and its laws and are free to spin our inner life, we see pictures and conduct dialogues or listen to then." Karl Jaspers did not understand this distinction. With suggestion one can induce a person to experience images but you cannot make a person see things through the senses with suggestion.

Hallucinations are not necessarily proof of psychosis, as witnessed by Freud himself:

I remember having twice been in danger of my life, and each time the awareness of the danger occurred to me quite suddenly. On both occasions I felt ‚this is the end,' and while otherwise my inner language proceeded with only indistinct sound images and slight lip movements, in these

situations of danger I heard the words as if somebody was shouting them into my ear, and at the same time I saw them as if they were printed on a piece of paper floating in the air (Freud, 1891, „On Aphasia," p.62).

Dreams, hallucinations and delusions were aptly called by Eugen Bleuler dereistic, from res a thing, not about things but about thoughts, according to their own laws, language, and logic. They not just wish fulfillments but also historical records of life's dramas and traumas. Like dreams, delusions and hallucinations can be decoded by reciprocal free association, or team work of patient and therapist. The dreamer, hallucinator and delusionist, is the author, the producer, the actor, and audience of his imaginary scenarios. These imaginary intrapersonal scenarios are traceable to interpersonal scenes, or dramas of conflict and crisis, desire and defense, as approached by dramatology.

From traumas and dreams to dramatology

Reporting on his cases it struck Freud as strange that the case histories he writes should read like short stories and lack the serious stamp of science; the nature of the subject is evidently responsible for this. However, a detailed description of the mental processes such as we are accustomed to find in the works of imaginative writers enables him to obtain an intimate connection between the story of the patient's suffering and the symptoms of his illness" (160).

According to Entralgo: "Freud discovered the absolute necessity of dialogue with the patient, assigned to the event of the illness in the over-all biography of the patient" (128, 130). These case histories were not only narratives and descriptions, they were filled with lively dialogues, i.e., conversations, expressing vivid memories of traumatic events, i.e., dramas. In common parlance drama means a big event or a state of mind that is very intense, highly emotional, and turbulent. There are thus major dramas and countless minor dramas of everyday life. Freud had an ongoing interest both in great novels and great drama, the latter shown by literature professor Gunnar Brandell in Freud a man of his century. The most famous Freudian complex, the Oedipus complex, was inspired by dramatist Sophocles. Another major influence was Henrik Ibsen.

The two literary genres used to portray human action and interaction, and to communicate the latter to another person or persons, are the narrative (from Latin narrare, to make known), i.e., telling stories to a listener, or writing books, and the dramatic (from the Greek root dran, to act), i.e., showing staged and enacted plots to spectators. Stories are primarily descriptive, either autobiographical (first person accounts) or biographical (third person accounts). Science also produces stories, research reports and case reports. The study of narratives, literary or scientific, is called narratology, and is found in dictionaries.

I proposed dramatology a word not found yet in dictionaries but now an entry in Wikipedia to complete narratology. As dramatologist I focus on the real person having an effect on me with a body, dressed in certain fashion; with a certain spiritual aura; engaged in communicating with words, facial expression and bodily gesture and posture; demeanor, mien, manner, mood and music of the spoken words—all shaping the meaning, the content and intent, of communications. Sociologically, dramatology is concerned with character, conduct, conflict, crisis, conscience, confession, and confrontation. Psychologically, dramatology is based on the function of dramatization, the ability to form images, imaginary scenarios involving actions, emotions, sensations, scenes, and speeches. Whereas narratology utilizes description and may contain conversation, dramatology is all action and conversation, utilizing both nonverbal mimetic expressive action and the spoken word. Dramatology is differentiated from dramaturgy, the art of writing, staging and performing dramas in the theatre, thus with fictional characters. Art imitates life, life creates art. Freud recalled that Charcot's lectures were derided as "theatrical by ill-disposed strangers" and the master's assistants later admitted they had coached the women to perform, as portrayed by the swooning Blanche Wittmann, the "queen of hysterics," falling into Babinski's arms, in that famous 1887 painting by Brouillet, a copy of which hung in Freud's waiting room at 19 Berggasse.

Although hysteria was removed from DSM-IV, Freud's conversion hysteria lives on there as "conversion disorder," one of the "somatoform disorders that do not conform to known anatomical pathways and physiological mechanisms but instead follow the individual's conceptualizations of a condition" (452), determined by their histories and imagination. There was only one step from hysterical, commonly meaning wildly and artificially emotional, to characterizing such conduct as histrionic, i.e., theatrical and extravagantly exhibitionistic, from the Latin word histrio, an actor, giving rise to DSM-IV histrionic personality disorder, "characterized by self-dramatization, theatricality, and the exaggerated expression of emotion." On stage actors impersonate characters in movements and in pantomime, or as in the social game of charades; similarly, a hysteric impersonates a paralytic but has no paralysis of any kind, neither organic nor functional, while a catatonic, displaying so-called waxy flexibility, impersonates a cadaver or a child controlled by his elders. How do we talk with such a catatonic?

Talking to the psychotic with love

At the international conference, The Origins of Schizophrenia, held in 1967 at my alma mater, John Romano's department of psychiatry in Rochester NY, a fiery Ronald Laing decried the lack of consensus about what schizophrenia is and ridiculed the circular talk of "psychiatrese": "schizophrenia is the name of a condition that most psychiatrists ascribe to patients they call schizophrenic." Similar doubts were expressed by other like minded participants, Theodore Lidz and Lyman Wynne, the future chief of the Department, focused on the family, social, and cultural contexts of these patients. Nowhere is dramatology more relevant than in family and group therapy. The proper question is what do in families and society, people called schizophrenics do, how do they act, interact and communicate in mutually enacted dramas, or transactions as Wynne put it, and how we as therapists interact with them. Since words and speeches were the principal interaction, I hope we can agree on one fact: most so-called schizophrenics speak a peculiar language. This was brought home to me by a book I picked up as a resident, Beulah Parker's 1962 My Language is Me Psychotherapy with a Disturbed Adolescent with a foreword by Lidz: "this book," wrote Parker, "is the story of a mutual learning process taking place between a troubled boy and his therapist. Each learned valuable lessons. The boy learned to allow another person into his private world to work on his conflicts. The therapist learned to talk a new language, to tune in on a highly personal thought process and to translate his code, his private language of vivid pictorial images," his "creative" use of metaphor, simile and allegory about various gadgets and machines into the reality of the persons, events, and emotions.

Just as the dreamt dream is larger than the recalled dream, so are schizophrenic thoughts and emotions larger than schizophrenic language, and for a number of reasons. (1) Thinking in words is preceded by thinking and emoting in the preverbal period when mother and child learn from each other about language and love, in processes of bodily contact, emotional communion, and communication with body gesture and mutually induced emotions. Mother and child adapt to each other to ensure the survival of the child. Such adaptation is biological and psychological. In animals there is a pre-established harmony in the dyad, among humans traumas in communication may occur. Whether these will cause future disorder cannot be settled. (2) As with the erroneous subordination of hallucinating to perception, psychiatrists have pathologized schizophrenic language and logic as concrete, primitive, paralogical (von Domarus) and regressive in comparison with the progressive Aristotelian logic and the ability to discourse and write in abstractions. However, as made clear by philosopher Susan Langer, emotional language and representational language are older than discursive language, the latter fit for expressing purely intellectual ideas. It is crucial to understand the thoughts, emotions, and language of the child.

Children do not separate perception from emotions feeling and sentiment from ideas. They operate with the primal unity of mind in which cognition is connected with or immediately followed by an emotion and varying degrees of action, a unity which psychologists called ideo-motor. Thus

emotions precede intellectual ideas and are later expressed in ideas. Children equate thinking with speaking and locate thoughts and speaking voices in various parts of the body, as we also find in the Bible (wisdom is located in the kidneys or adrenals and emotions in the belly) and in aboriginal people. Moreover, children also think in vivid eidetic, pictorial images. It is grave prejudice that children live only in fantasy and do not know reality: on the contrary, children are exquisitely attuned to reality and they know the difference between pretending and perceiving in their games with dolls and soldiers. Similarly, Schreber located his voices in nerves and called the process "nerve language and inner voices: I receive light and sound sensations which are projected direct on my inner nervous system by the rays; for their reception the external organs of seeing and hearing are not necessary." Paul Federn, a prominent investigator of the psychoses, noted that in the schizophrenic "we treat several children of different ages." To conclude that the psychotic is totally psychotic, or that he becomes a child, is an instance of a déformation professionnelle, a tunnel vision of the professional, for the adult is no more a child and no matter how sick, still operates with a part of his healthy personality, e.g., as shown by the now forgotten French psychiatrist Henri Baruk.

Children possess emotional intelligence. They know straightforwardly the intimate relation between love magic and word magic. They know that life is love and that frustration, trauma, and hate can destroy life and love. Disorders in childhood and adulthood are primarily emotional: love crises caused either by lack of love, excess of love, or distorted love. Thus, anxiety is fear of losing love; depression is mourning love lost; mania is excess of love; paranoia is jealousy and envy over love; sadism and masochism – distorted love; hateful aggression, destruction of love. It is love dramas and love crises that make people suffer and seek therapy.

Crises of love are the core of the dramas and traumas of love and expressed with particular poignancy in people characterized as schizoid, schizothymic, and schizotypal, with their qualities of body build, Kretschmer's sensitives (leptosome, asthenic vs. pyknic), with their habits of thinking and feelings, that determine their reactions to stimuli in interpersonal relations and situations. They are exquisitely aware of the real impact other people have on them and are ever so sensitive and vulnerable and easily wounded, i.e. traumatized, by others. Consequently, they either retaliate angrily or violently to the trauma of frustration or withdraw into apathy, autism and into autistic reverie or autistic talk. Their coldness and grandiose self-sufficiency are strangely fascinating. If the hysteric is ingratiating like a dog, the schizoid is aloof like a cat.

In the spirit of dramatology, when talking with the psychotic

There are no diagnoses, there are individual life dramas and life histories, remembered or enacted;

There are no universal dynamics, there are expressions of emotions in the here-and-now, expressing actual contents and intents, present needs and desires;

There are no formulas for interpreting, there is becoming aware of conscious and unconscious processes in the form of gestures, words, metaphors, images, fantasies, communicated back and forth between and listener. You educate with love.

Harry Stack Sullivan, who promulgated The Fusion of Psychiatry and Social Science and made interpersonal a household word, taught: „All of us are much more human than otherwise. When the satisfaction or the security of another person becomes as significant to one as one's own satisfaction or security, then the state of love exists." Leaders in the field of psychoses recommended same: educate, teach, raise the psychotic with love, commitment, sympathy, and optimism; kindness, interest, and unrelenting patience; acceptance without reservations and without retaliating the patient's frustrations or expression of aggression hostility, scorn, suspiciousness, or any other sign of hostility; avoiding pretending or lying; being flexible with listening and talking, being receptive and active. This was clear to pioneers Adolf Meyer, Sullivan, Gustav Bychowski, Gaetano Bendetti, Martti Siirala, John Rosen, Frieda Fromm-Reichmann, Harold Searles, and the here present Iryö Alanen, John Martindale, Ann-Louise Silver, Brian Koehler and many others. Theodore

Lidz, Lyman Wynne, and Helm Stierlin applied these principles to family therapy. Dramatology is particularly relevant in family and group therapy of psychotic people, both as scripted psychodrama and as spontaneous dramatic interactions.

The authors just named did not view the psychotic person as an alien separated by a gulf from the rest of humanity. The ability of the psychotic to dramatize has been understood and utilized therapeutically by John Rosen in his method of direct analysis, a term suggested to him by Paul Federn. Rosen acted to "awaken the dreamer by unmasking the real content of the psychosis. Since the patient acted as an infant, the therapist must be a loving, omnipotent protector and provider, he must be the idealized mother who now has the responsibility of bringing the patient up all over again. The direct lets the sufferer know that his mumbo jumbo signals, like those used by the infant, are being understood." This was not only dramatology but also psychodrama, a method created by Jacob Moreno in the USA and then all but forgotten by thriving in Europe. Gaetano Benedetti, whom Manfred Bleuler sent to study with John Rosen, employed this active method in his treatment of Otto Lehner in 1954. Benedetti approached Lehner's delusions as enactments of a traumatic relationship with his parents. Viewing the patient as a traumatized child, Benedetti played a psychodrama role of the caring father and interpreted the homosexual motif not as a sexual desire but as a desire to be loved by father, a replay of his childhood father-son drama, providing a corrective emotional experience, this method was also utilized by Marguerite Sechehaye as symbolic realization. Admiration for Benedetti was expressed by Martti Siirala in his books Die Schizophrenie des Einzelnen und der Allgemeinheit (1961) and in From Transfer to Transference (1983), which he inscribed for me. Siirala wrote about treatment as an encounter, of "the humor in the schizophrenic situation," "the interpersonal character of human illness," the body as an interpersonal communication, the role of love, of what he called "transfer," the "burden of mutual responsibility" in society, reflected in the "multi-phased drama" of the treatment situation.

The word as trauma

There is no psychosocial disorder in which psychic trauma does not play a causal role: it is an omnipresent, superordinate dynamic that cuts across all interactions in life and disorder, including the psychoses. While in Freud trauma was discovered, repressed, and resurfaced after WWI in Beyond the Pleasure Principle in 1920, the future posttraumatic stress disorder and in his last work, Moses and Monotheism in 1938, Freud's most faithful disciple, Sandor Ferenczi, never lost sight of the role of trauma in the genesis of disorder and in therapy and in the dramatology of love and was the first to write about adaptation.

I want to emphasize the role trauma and stress in the homeostasis of therapeutic interactions as mutual adaptations: the ups and downs between harmony and dissonance, safety and danger, frustration or gratification of needs; the ebb and flow of powerful emotions, friendly or hostile, erotic and aggressive. As in everyday life, words can hurt or heal, cut and console, sear and sooth, hurt and heal. Moreover, words can reveal and conceal the intention of the speaker who can speak truthfully or lie, create distrust instead of trust, hide dislike under a cloak of hypocritical benevolence. Such interactions are traumatic and require recognition and repair through self--regulation and reciprocal regulation.

Some lessons of history

Three professors gave opinions about psychiatry.

(1) Prof. Kraepelin in 1918 held that "the key to the understanding of insanity is to be found in the condition of the brain."

Kraepelin's scientific methodology was twofold: 1. to reduce mind to matter; 2. to collate, classify, and convert, by abstracting and generalizing, a multitude of individual observations written down on his famous index cards into classes of disorders and diagnoses. In this way a static descriptive science was created fit for teaching and writing textbooks. But whereas a medical disorder can be approximated to a species morbosa à la Sydenham, or a botanical or zoological species

à la Linné, pace Kraepelin, a psychiatric disorder cannot. For a symptom in medicine, e.g., fever, is a sign of a condition, pneumonia, revealed by observation of other physical signs and tests. A so-called symptom in psychiatry is an act, a form of conduct, a drama. It is not in the brain, it is between people: It takes one to get pneumonia; it takes two to tango, two to talk, two to create paranoia. Somatic disorders and their diagnoses are discovered, diagnoses of behavior disorders are invented.

Psychiatry's concern is not with an organism or an abstract universal but with a person, sane or insane, who acts and interacts: the concrete, particular, and unique individual with physical, psychological, and cultural attributes of character and a history. With a patient with pneumonia we do observation and auscultation, with a patient who voices strange ideas we relate, as Sullivan taught, through participant observation in a conversation, which means empathy. As shown by J.G. Scadding, essentialist "'definitions [of disease], attempting the impossible task of revealing the essence of the definiendum, have no place in science" (p. 243). A contrast to psychiatric essentialism is existentialism: as stated by Sartre, existence precedes essence.

Scientific organic psychiatry and somatic therapies are one domain, an interpersonal psychosocial psychiatry and psychotherapy are another. Interestingly, the 5th edition of Kraepelin's Textbook, which Schreber cited, did contain well-written chapter on "Psyschische Behandlung" of insanity, citing Freud's 1893 translation of Bernheim's New studies on hypnotism, suggestion, and psychotherapy. He also mentioned Emotionspsychose and deplored the excessive preoccupation with the intellectual at the expense of the emotional issues in paranoia.

Eugen Bleuler's method in schizophrenia, while respective toward Kraepelin, was a significant departure; it was preceded by views about psychosis from first half of the 19th century that Kraepelin derided as "facile," "naïve" and "arbirtrary," "a medley." In France Pinel and Esquirol practiced traitement moral, i.e., psychotherapy. In Germany, psychological psychiatrists were called Psychiker: Johann Christian Heinroth (b. 1773), appointed professor of "psychische Therapie" at Leizpig U. in 1811, taught that mental health is freedom and illness loss of freedom as a result of self-love and other passions, i.e., emotions (212), causing delusions. Similarly, Karl Wilhelm Ideler (b.1795), claimed that unsatisfied sexual desire causes flight into fantasy and that delusions should be traced to earliest childhood. In 1845 Wilhelm Griesinger (b. 1817) famously declared that "mental diseases are brain diseases" and paved the way for the defeat of the Psychiker by the Somatiker, the organicists, and the rise of an organic and mechanistic psychiatry.

The tradition of the Psychiker came back in the late 1880's with two Swiss psychiatrists, Forel and Bleuler. Aguste Forel (b.1848), author of a book on hypnotism reviewed by Freud and later famous as a myrmecologist and sexologist, was the teacher of the Swiss-born Adolf Meyer (b. 1866), architect of psychobiologic psychiatry in the United States and author of the first DSM of 1950 in which psychoses were called reactions to social stresses in course of a person's lifetime. Reactions were renamed disorders from in DSM-III, built on Kraepelin's system, in which hallucinations and delusions are seen as the principal diagnostic criterion of schizophrenia and with no mention of affects.

Bleuler renamed dementia praecox schizophrenia and provided a handy adjective, schizophrenic and differentiated primary disorder, the four A's: (1) associations, their loosening caused by an organic-toxic lesion of the brain, and (2) affect, (3) ambivalence, and (4) autism, the last three pertaining to the person's emotional life, from the derivative, secondary disorder of delusions and hallucinations. The root 'schizo", splitting, indicated a detachment of emotions form ideas. But autism in Bleuler had two meanings: in 1911, in the book: (1) withdrawing from interpersonal relationships and the world, in 1912, in an essay published in the Jahrbuch edited by Jung: (2) autistic thinking, day dreaming and wish fulfillment, to create a compensatory inner world to fill the void created by the withdrawal from the real one.

(2) Prof. Schreber h.c. in 1903 warned "psychiatry not to tumble with both feet into the camp of

naked materialism, for it will have to recognize real happenings which simply cannot be brushed aside with the catchword 'hallucinations'" (p. 90). There was no way psychiatrists armed with perceptionist theories of hallucinations would understand Schreber.

The historical Schreber came to life with the researches of Baumeyer, Niederland, Israels, Devreese and provided missing links in Schreber's autobiography. I reinterpreted his three illnesses, 1884 (moderate), 1893 (sever), and 1907 (deadly), as depressive reactions triggered by the traumas of loss and crises of love.

At age 51, in the fall of 1893 (after his wife gave birth to a dead boy, her sixth failed pregnancy), Schreber developed intractable insomnia and an agitated suicidal depression, which he correctly diagnosed as a mood disorder. Flechsig promised a cure with drugs and chemical shock treatment. At the end of the allowed stay of 6 months Schreber was discharged by Flechsig to end up in a public asylum, a disgrace for a high court judge and an end to his career. He wanted and needed psychotherapy and only got it once from Flechsig's junior assistant.

In his flight into illness he expressed the traumas and dramas of love in florid cosmic fantasies. His fantasies of turning into a woman, out of sympathy for his wife's unconsummated motherhood or his own wish for children, were a feminine identification, not any sexual desire to be anally penetrated by Flechsig, an expression of homosexual dread (Socarides). Soul murder was such a cosmic catastrophe traceable to his quoting from The Book of Job and Goethe's Faust, with prologues in Heaven in which God delivers an innocent man to Satan. There was no paranoia and no homosexuality.

Similarly, Schreber's Job-like torments, described in his Chapter XI: the various Wunder (miracles), were actually imaginary wounds, i.e., his emotional reactions to the trauma of being admitted to Sonnenstein, from which he tried to escape, the humiliating conditions of life there. These were not any memories of having been tortured by his father with horrific "machines" at age four to five, as imagined by Niederland.

Towards the end of his stay at Flechsig's the crisis on earth was complicated by a money dispute with his wife who upon the advice of his boss obtained a temporary declaration of incompetency to gain control of the money. In the "Open Letter to Prof. Flechsig," added just prior to publication, Schreber accused Flechsig of abandonment and malpractice. Director Weber was "only acquainted with Schreber's pathological shell which concealed his true spiritual life" (297). The English translators of his book left out the subtitle of his book: "in what circumstances can a person considered insane be detained in an asylum against his declared will?" Schreber's alleged paranoia was mirrored in Weber's institutional paranoia (Irving Goffman).

Schreber felt fit to leave the asylum in 1897 continued to he detained imprisoned against his will by Weber whose negative diagnoses made the incompetency permanent. Schreber sued the state and won against Weber, a legal precedent. In a 1905 anonymous report Weber claimed Schreber's release was a mistake and predicted failure. Schreber proved him wrong again. He spent five good years back with his wife, in a new house he built in Dresden, raising with love an adopted daughter who was interviewed by Niederland in 1969. I got to know his adoptive grand--daughter who gave me as gift Schreber's book with a handwritten dedication to his wife.

Schreber wrote in realistic prose and in the style of magical realism. He repeatedly applied the qualifier "as if" his visions and voices and spoke against the "powerful of this earth with fiery words, Flammenworte, like Jesus against the Pharisees or Luther against the pope."

(3) Prof. Freud in 1911: "The interest felt by the psychiatrist in Schreber's delusional formations is not the beginning of understanding. The psychoanalyst holds that even thought-structures so extraordinary as these and so remote from our common modes of thinking are nevertheless derived from the most general and comprehensible impulses of the human mind and discovers them in such a transformation. He goes more deeply into the details of the delusion and into the history of its development, to lay bare the familiar complexes and motive forces of mental life, to find

ourselves in possession of a translation of the paranoic mode of expression into the normal one." This passage defines the principles that illuminate Freud's profoundly ethical and humanistic approach to psychosis an his tearing down the wall separating the sick from the healthy. However, Freud did not fulfill the task he set himself in interpreting Schreber, for he admitted that "any one who was in touch with Schreber's family or the society in which he moved and the small events of his life would trace back innumerable details of his delusions to their sources," which he had done in the case of a woman he published in 1896.

By contrast, Freud did not research Schreber's history nor did he ask his man in Dresden Dr. Stegmann, to do it for him, even find the expurgated third chapter of Schreber.

Furthermore, he declared that he "can call a friend and fellow-specialist [either Jung or Ferenczi] that I have developed my theory of paranoia before I became acquainted with Schreber's book." Surprisingly, he mentioned Jung's book in passing. Clinical cases of treatment of psychosis were published by Maeder (1910), Bjerre (1911), Spielrein (1911, cited by Freud SE 12:80), Ferenczi (1911).

At best, his analysis was an exercise in applied analysis, at worst, it was a kind of wild analysis based on prepared formulas.

Interestingly enough, Freud did not claim that his interpretation could be used to treat Schreber's psychosis. How could it help Schreber to be told that he was his paranoia was caused by a desire to be sodomized by Flechsig, as early as the summer of 1893, before he saw his doctor in person in November? In fact, Freud concluded that Schreber cured himself: "The delusional formation, which we take to be the pathological product, is in reality an attempt at recovery, a process of reconstruction," an amazing statement for his time. More tellingly, he opened Freud's eyes to the importance of "ego-cathexes" and "ego-interests" which inspired Freud to publish his 1914 landmark essay "On narcissism: an introduction," where ego psychology was born. Instead he relied on Weber's forensic reports, equivocated between the diagnoses of paranoia, paranoid schizophrenia, and paraphrenia, a sterile exercise. He had done so much better in his analysis of analyzing a stark contrast to his first published clinical case of a woman with hallucinations and delusions in 1896 or his 1907 analysis of a fictional story in his "Dreams and Delusions in Jensen's Gradiva.

Coda

In a letter to Jung Freud raved about "the wonderful Schreber, who ought to have been made a professor of psychiatry and director of a mental hospital." Schreber's book is indeed wonderful: not just a clinical dossier. It is a life drama that resulted in a spiritual awakening to yield a creative literary work, a philosophical essay, a wellspring of seminal ideas for psychiatrists, psychoanalysts, philosophers, and writers ever since. It was his creative illness, his "journey through the unconscious" (Ellenberger, 670), producing "the conviction of having discovered a grandiose truth that must be proclaimed to mankind" (450). His insights about androgyny, the feminine in man and the masculine in woman, ideas that permeated the Gnosis and the Kabbalah, inspired Jung's animus/anima theory. His important ethical lesson embodied that old Hebraic idea: "Whoever destroys a soul, it is considered as if he destroyed an entire world. And whoever saves a life, it is considered as if he saved an entire world." He bequeathed upon us an unforgettable, wondrous legacy.

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