

## **Psychotherapy and Schizophrenia**

Various medical therapeutic techniques have been used over the years in the treatment of people with schizophrenia. From pharmacotherapy to electrical shock treatment, the aim of these methods has always been the attainment of a solid base from which a stabilization of the person and a rebuilding of his/her personality could take place. It was recognized that pharmacological treatment provided people with mental illness with symptomatic relief and enabled them to resume many of their daily activities. The popularity of a medical model, that focused on the medical aspects and causality of the illness and the perceived use of pharmacological intervention as its main tool, increased with the rapid development of new and more powerful psychotropic drugs in the second half of the 20th century. This development prompted a strong emphasis on cheap, fast-acting pharmacological drug treatment, perceived to be more cost effective than long term, expensive in-depth psychotherapeutic interventions. In cases where psychotherapy was still considered in this medical model, mostly concrete behavioural and cognitive approaches, perceived as suitable complementary treatment methods to the use of drugs, were employed.

Karon (1991) strongly opposed this trend. According to him “psychotherapy is the treatment of choice for schizophrenia” (p. 1). In line with the theories of Jung, *Schizophrenia* 137 Harding, and Bion, one might conclude that psychotherapeutic work with people with schizophrenia should mainly focus on ego repair and on the restoration of the ability to establish relations between internal aspects of the psyche and between inner and external realities. Can this goal be achieved? Bion (1990), contrary to Freud, believed that the ego is never “wholly withdrawn from reality . . . but its contact with reality is masked by the dominance, in the patient’s mind and behaviour, of an omnipotent fantasy that is intended to destroy either reality or the awareness of it” (p. 46). This process, according to Bion, creates a situation in which, throughout a schizophrenic episode, the ego is viciously attacked. Therefore, he emphasized, ego repair should be the main goal of psychotherapy with people with schizophrenia. He further suggested that the emphasis of a therapeutic process should be on providing the ego with the tools it requires to reclaim its ability to cope with external reality.

The attempt to think, which is a central part of the total process of repair of the ego, involves the use of primitive pre-verbal modes, which have suffered mutilation and projective identification. This means that the expelled particles of ego, and their accretions, have to be brought back into control and therefore into the personality. . . . [This] projective identification . . . [could be] reversed and these objects . . . [could be] brought back by the same route as that by which they were expelled (p. 61).

In antiquity, when people needed support or healing, they would go to medicine men that, in their own cultures, were considered to be healers. This trend was also true in modern Western cultures in which psychotherapy evolved to be “the most celebrated technology . . . for intervening in the internal models, the personal myths, that are at the core of ongoing experience” (Feinstein, 1997, p. 508). Naturally, this statement elicits questions regarding the nature, meaning and process of psychotherapy. Many professionals have tried to answer these questions. Bion (1978), for instance, stressed that, for therapy to work, there is a need to have an external human agent who will help in the process of realization and in the activation of the therapeutic process. The questions he posed dealt with issues such as: “Why is an external person needed?” and “Why can’t one have a relationship with oneself directly without the intervention of a sort of mental or physical midwife?” Bion answered: “It seems as if we need to ‘bounce off’ another person, to have something which could reflect back what we say before it becomes comprehensible” (p. 34-35).

Jung (1985) also responded to such questions by saying that psychotherapy is “a kind of dialectical process, a dialogue or discussion between two persons . . . [in which] a person is a psychic system which, when it affects another person, enters into reciprocal reaction with another psychic system” (p. 3). Reflecting on Jung’s analytical psychology, Frey-Wehrin, Bosnack and Robinson

(1980) stated that therapy did not mean a kind of objective treatment. It meant an encounter and engagement in which both the therapist and the therapeutee partners were deeply involved.

Taking into consideration the above responses one might enquire whether such a psychotherapeutic process really works, and whether it works for everyone, including people with schizophrenia. Additionally, one might also enquire whether there is a difference between various psychotherapeutic methods and, if so, which is the best modality.

By comparing the outcome of various therapies, several researchers explored the effectiveness of diverse therapeutic modalities attempting to find an answer to these questions. Revolutionary research in 1954 (Whitehorn and Betz, cited in Bergin & Garfield, 1971) concluded that effective psychotherapy is not dependent on a specific psychotherapeutic orientation or methodology. Rather, researchers discovered that therapy was successful when the therapist was warm and accepting and attempted to understand the patient in an immediate, personal and idiosyncratic way, focusing on the person and not on a specific psychotherapeutic modality. Empathy, non-possessive warmth, and genuineness brought about constructive change, while rigidity and theoretical fixation were found to be deterrents, even when the therapist possessed a high and proficient level of theoretical knowledge.

Since Whitehorn and Betz, many other researchers have come to the same conclusion. Kaplan, Sadock and Grebb (1994) argued that concerned therapists, who offer human compassion and a sanctuary from a confusing world, become the cornerstones in every therapeutic process. Kalsched (1996) talked about the effect of a mother's approach on her child. His words can be generalized to the therapeutic relationship and the approach used by therapists. Kalsched said: "Negative, aggressive affects tend to fragment the psyche (dissociation), whereas positive, soothing affects accompanying adequate mediation by the mother [therapist], have the effect of integrating these fragments and restoring homeostatic balance" (p.18).

Good therapists, explained Schulz (1985), have to be constantly aware of who they are and what their motives are. They need to be able to observe themselves and be willing to learn from the processes in which they participate.

Successful psychotherapists must be able to empathize with their patient's problem without being either overwhelmed or over fascinated with it. . . . The successful therapist must in some way convey an emotional involvement with each patient. . . . One must allow oneself to become immersed in the process. There must be an ability to tolerate ambiguity and uncertainty without having the ready answers that seem to be so much a part of conventional medical school training. The capacity to experience and contain a range of . . . [transference and] counter transference feelings, and the opportunity to resolve these feelings . . . seem to be essential. (p. 740)

Hillman (1976) added another element to the above. He suggested that therapists, who are unable to conquer their own therapeutic helplessness and feelings of fear, aggression and/or rejection evoked in them by the therapeutic content, will be unable to accept their clients. Such therapists, he argued, will try to overpower their clients and enforce "change" rather than accept them and "be" genuine with them. According to Hillman, this will result in stagnation and failure of the therapy, leaving both therapist and therapeutee in limbo.

As we have seen, the practical implementation of acceptance of the therapeutee, and a positive, warm attitude, and the therapist's deep belief in the integrity of the therapeutic process and ability and willingness to become conscious of personal issues, are the main factors that ensure a successful psychotherapeutic process. Are these factors also crucial when we speak about working in psychotherapy with people with schizophrenia?

Freud, who perceived psychosis as a conflict between the ego and the external world, had a pessimistic viewpoint regarding the ability of persons with schizophrenia to form transference relationships, which according to him, were necessary for any therapy to work. Freud's argument became a strong deterrent, in some medical circles, to the application of psychotherapy in the field of schizophrenia. In the United States, through the work of people like Tausk, Fairbairn and Sullivan, psychotherapy for people with schizophrenia started to be viewed in a more favourable fashion (Schulz, 1985). Sullivan, who was alleged to have suffered a psychotic breakdown himself for which he was hospitalized for two years, was instrumental in the development and implementation of psychotherapy with people with schizophrenia in clinics and mental institutions. Sullivan believed that "the schizophrenic suffers an almost unceasing fear of becoming an exceedingly unpleasant form of nothingness by a collapse of the self" (Schulz, 1985). He gave careful attention to the reconstruction of the milieu of the patients, stating that environmental factors, such as the therapist's attitude and approach, play a crucial role in the success or failure of the therapy.

Acknowledging the need for psychotherapeutic support, Harding (1973) argued that the purpose of conventional medical methods was reduced to the sole reconstruction of functioning and that these methods were "not designed to give the patient insight into his problem or understanding of his psychotic experience" (p.287). She stressed that this situation changes completely if a person with schizophrenia is treated with psychotherapy. Therapy teaches the person to understand the "alien material that has broken through into consciousness and helps him to reconcile his former attitudes and values. . . . [As a result] the patient may gain from his psychological illness a higher level of consciousness and greater inner integrity" (p.287).

A quote from an anonymous writer (cited in Kelsched, 1999) states: "Therapy is not about relieving suffering, it's about repairing one's relationship to reality" (p.100). If this holds true when we talk about therapy generally, it is imperative when we describe the goals of the therapeutic process of people with schizophrenia.

Karon and VandenBos (1981) argued that psychodynamic analytical therapy has produced significant gains, particularly in cases in which therapists are experienced in dealing with the difficult therapeutic problems presented by individuals with schizophrenia. They also stated that therapists working psychodynamically with people with schizophrenia have to constantly invest energy in on-going introspection and inner reflection if they are to serve their patients properly.

Therapists, who out of fear and helplessness, are unable to become cognizant of the disturbed, psychotic dynamics and delusional phenomena presented by their patients and, who express an undertone of aggressive, scared countertransference, hinder the therapeutic process and cause harm to the therapeutee (Hillman, 1976). Harding (1973) also spoke about the possibility of a therapist's fear and its effect on the therapeutee. She explained that the therapist has to be able to accept without fear the person in his/her own reality. By doing so, the therapist will provide the therapeutee with a container within which grounding can take place. Through confidence in "the regulatory powers of the unconscious which far surpasses our conscious potentialities" (Frey-Wehrin, Bosnack, Langeager, and Robinson, 1980, p. 247), the therapist as empathic companion will be able to support the patients in their difficult journey and provide them with a safe container.

*Without any warning Rhonda, who had never considered medication, physically attacked me during our session. At this early stage of her therapeutic process she was still very confused, at times controlled by delusions, and full of anxieties. This affected her ability to think coherently and prevented her from functioning properly in her daily life and at her job. I had to restrain her and help her calm down. The incident lasted about twenty-five minutes during which I provided her with the support she needed, reflecting, in a soothing voice, her fears, loneliness and anger. Calmer, she later explained that she became physically aggressive towards me*

*because she felt that I was critical of her like the Witch inside of her, who was trying to destroy her by attacking her with a knife. She said that while she felt guilty for the attack she also felt safe knowing that I was able to cope with such an extreme situation without being afraid of her. After the session I was thinking about my experience, about how I had to physically restrain her and how difficult it was for me to contain the transference, about Rhonda's projection of the Witch, and about the countertransference angry feelings the attack evoked in me. Internally I had to struggle with strong negative feelings and work hard to clarify their source in me. I knew that, for the therapy to continue, I had to find acceptance, empathy and love within me so that I could provide her with the safe container she required. This incident stayed with me for a long time. Every so often in her sessions, I found myself reflecting internally upon my own struggles with the difficult projection of the vicious Witch and the intense personal process it required of me. On the other hand, however, even within this turmoil, Rhonda periodically expressed feelings about her therapy experience, in which, for the first time in her life, she felt unconditional acceptance and love.*

Can Sandplay assist in creating a container that will be experienced by people with schizophrenia as "safe enough"? Can it promote grounding? Can it uphold ego repair? Can it help the person with schizophrenia to relate and make the necessary relational connections both in the external and inner world?