CHAPTER 13

THE PSYCHOTIC PATIENT

The psychotic patient poses special challenges for the interviewer. The patient with acute psychosis may be agitated, incoherent, and frightened, or he may be euphoric, aggressively overbearing, and delusional. For the interviewer who has had limited clinical exposure to patients with this degree of mental disturbance, considerable anxiety will be aroused, mirroring, to some extent, what the patient is also experiencing. While inwardly acknowledging this shared aspect of subjective state, the interviewer has to adopt a highly empathic response to the disorganization or heightened mood of the psychotic patient, one that is predicated on an attempt at understanding. What is the patient experiencing? How does he understand it? What does it mean for him? To some degree, the interviewer has to function as an external ego for the acutely psychotic patient, empathically connecting to and acknowledging the disruption of personality and the emotional storm that is sweeping through the patient.

The patient who has a chronic or insidious-onset psychosis poses a different set of problems. He may be suspicious, uncooperative, and withdrawn. Again the interviewer has to be highly empathic, patiently attempting to gain access to the patient's hidden world. The immediate countertransference danger for the interviewer dealing with either the acutely or chronically psychotic patient is that of objectifying him as "crazy" and "not-me." This is a defensive response in the interviewer engendered by an unconscious fear that "I, too, could become like this." As Sullivan aptly observed, the psychotic patient is "more human than otherwise." Being constantly cognizant of the validity of Sullivan's observation is crucial for establishing rapport with the psychotic patient and ensuring that the interview is therapeutic.

During the 1940s and on into the 1950s, Harry Stack Sullivan and his
contemporaries at the Washington School of Psychiatry, William Alanson White Institute, and Chestnut Lodge were particularly interested in the psychotic patient. Papers published by Frieda Fromm-Reichmann, Harold Searles, and others emphasized an empathic approach that they believed was helpful to these patients. They listened with great sensitivity in order to help the psychotic patient find understanding in the midst of internal chaos. Many psychotic patients responded to their clinician’s attempts to understand them and bring some degree of order to their inner disorganization.

These patients were able to recognize the clinician’s efforts to reach them, but this did not “cure” their psychosis. By the mid-1950s reserpine and chlorpromazine had been introduced as antipsychotic agents, and they often had a dramatic therapeutic impact, particularly with the acutely ill patient. Lithium carbonate became a standard treatment for bipolar illness in the late 1960s. Since that time, there has been a continuing development of newer and better antipsychotics. Unfortunately, this positive therapeutic development has led to a marked diminution in the attention given to understanding the subjective experience of the individual psychotic patient. Fewer clinicians have been interested in making sense out of the patient’s strange behavior and peculiar communications except for the purpose of diagnostic classification and neurobiological research. In the clinical situation, psychosis has often been reduced to being simply a manifestation of disturbances in the patient’s neurochemistry. Although we recognize the great value and potential therapeutic importance of neurobiological research and believe that psychotic disorders have an “organic” etiology, this chapter is dedicated to the psychological means of establishing a deep connection with the psychotic patient. We do not subscribe to a dualistic view that sees psychosis as simply a “brain disease” separate from the patient’s psychological issues, neurotic conflicts, and problems in ordinary life. Psychosis is expressed through the personality of the individual patient; hence, that person’s psychology, personal history, and particular character structure determine many aspects of the psychotic experience and should be recognized and addressed in both the interview and ongoing therapeutic work.

Like anyone else, the psychotic patient has neurotic conflicts. These may be obscured or exaggerated by the gross disruption of normal psychological function that the psychosis entails, but they should be recognized nonetheless because they will form the basis for psychotherapeutic work alongside appropriate psychopharmacological interventions. Psychodynamic insight into the personal meaning of the disorder and into the patient’s capacity for attachment to others, especially the ther-
apist, forms an essential foundation for therapeutic efforts. This makes the initial interview of critical importance. An interview with an empathic, connected, and unfrightened clinician who can accept the patient in the acute or chronic phase with all of his or her frightening or strange symptoms will often later be remembered by the patient as a positive, crucial healing experience. One sometimes encounters the mistaken notion that the acute, disorganized psychotic patient cannot be interviewed until he is medicated. A beginning psychiatric resident told his supervisor of a newly admitted psychotic patient: “I haven’t interviewed the patient yet. We are waiting for the antipsychotics to work.” They went to see the patient; the supervisor interviewed the patient, who calmed down and was responsive in the interview even though the medication had not yet taken effect.

Frequently the beginning clinician does not fully appreciate the patient’s capacity to move into and out of psychotic mentation in a particular interview. In the days before the advent of modern antipsychotics, a recovering patient would often say, “Thank you for the hours that you sat with me. I felt that you cared despite the fact that I was so incapable of participating in the session.” Although psychodynamic mechanisms are readily observable in psychotic patients, they do not cause the illness. Nevertheless they do reveal the patient’s unconscious psychological conflicts.

In the absence of knowledge of specific biological markers, psychosis remains a phenomenological diagnosis. This is reflected in DSM-IV-TR. Psychosis represents a spectrum of disorders acute and chronic, and the reader is referred to DSM-IV-TR for delineation of the diagnostic criteria that differentiate among them. The clinician’s greatest contribution to both the initial interview and ongoing therapeutic work with the psychotic patient, alongside appropriate somatic interventions, is the maintenance of a thoughtful, sensitive, and, most important, highly empathic posture that can have a healing effect in its own right. This chapter focuses on the influence of psychosis on the interview.

**PSYCHOPATHOLOGY AND PSYCHODYNAMICS**

**The Acutely Psychotic Patient**

*Positive and Negative Symptoms*

The acutely psychotic patient usually presents with gross disturbances of thinking, affect, and behavior. The patient may appear profoundly mentally disorganized and behaviorally inappropriate. The interviewer
should understand that he is encountering a massively altered state of consciousness causing, in the case of the schizophrenic patient, a frightening and phantasmagoric subjective experience or, in the case of the manic bipolar patient, often a wildly elated and euphoric experience. The acutely psychotic bipolar patient can, however, present with extreme dysphoria and agitation. The common thread in the acutely psychotic bipolar patient appears to be a radical *heightening* of mood states, whether euphoric, dysphoric, or mixed, accompanied by racing thoughts and increased psychomotor activity.

One conception of acute psychosis postulates three main sets of determinants. First, neurobiological disturbances lead to heightened awareness and intensification of normal sensory experience together with the invasion of perceptual and cognitive modalities. One patient described the onset of his illness in the following words: “I felt that the sun had filled my body and that light was emanating from me. I was radiant, a special enlightened being directly in touch with God.” This initial ecstatic experience was transient and rapidly replaced by feelings of persecution and tormenting auditory hallucinations accusing him of evil. A second group of determinants are individual and reflect the patient’s personality, history, and neurotic conflicts. These determine the particular content of the psychotic experience. “My father is the most dangerous person in the universe and must be destroyed,” declared an acutely psychotic young man who was envious and in awe of his father’s considerable financial power and influence. Finally, it is the psychosocial context of the patient’s current life that determines the initial clinical presentation. A freshman college student who had been extremely homesick and anxious during his first two semesters became psychotic when he returned to college at the end of the spring vacation. Used to having his own private bedroom as a teenager, he had been particularly disturbed at having to share with a male roommate, a situation that had made him acutely self-conscious and uncomfortable. When he returned to the campus, he had the conviction that the whole university had been subjected to a nuclear holocaust and that everyone was dead. “I was walking through a huge cemetery covered in gray ash.” This patient’s illness responded well to a combination of medication and psychotherapy, and he went on to marry and have a productive career.

A useful clinical distinction has been made between the positive symptoms—hallucinations, delusions, thought disorder, and anxiety-driven agitation—found in both acutely schizophrenic and psychotic bipolar patients and the negative symptoms usually found in schizophrenia alone. Positive symptoms may reflect an exaggeration and
elaboration of normal psychological processes. They commonly have “meaning” in terms of their content relevant to the psychodynamics of the individual patient. Negative symptoms, which include blunted affect, impoverishment of thought, apathy, and the absence of pleasure in life (anhedonia), may be a reflection of the loss of ordinary psychological functions. This diminution of normal psychological experience is generally associated with chronic or insidious-onset forms of schizophrenia. Although less dramatic, and less “crazy” to a layman, the negative symptoms are associated with a more dire prognosis, are more resistant to treatment, and cause greater suffering over the course of the patient’s lifetime.

**Disturbances of Thought and Affect**

**The manic patient.** The acutely manic psychotic patient is often agitated or excited as if the psychic “thermostat” has been turned to high. The torrent of words, ideas, and tangential associations to external stimuli that pour out of the patient may elicit in the interviewer a sense of being overwhelmed. The affective state may be one of elation and wild expansiveness, a type of extreme grandiosity that can lead to spending sprees, promiscuity, and insistent claims by the patient for his genius and originality. The expansive mood state has an “enthusiastic” quality to it—everything within the patient’s purview is “wonderful,” “extraordinary,” “marvelous,” “original.” The relentless energy and grandiose exuberance of the manic psychotic are exhausting to all around him, including the interviewer. Sleep disturbances are common, usually manifested in a radically decreased need for sleep. The manic individual will stay up all night telephoning friends, superficial acquaintances, and public agencies, barraging them with ideas, plans, and irrational schemes. Elation and euphoria may alternate with periods of intense irritability. When challenged or thwarted, he may become enraged and furious at the person who questions his extravagant claims and behaviors. The psychotic manic patient seems to have a type of psychic storm: tempestuous, wild, and wind-blown. It seems like a cerebral “discharge” phenomenon, overwhelming the surrounding psychological landscape with its fury. A bipolar patient described the ecstatic onset of his psychosis as follows: “From the very beginning, the experience seemed to be one of transcendence. The ordinary beauties of nature took on an extraordinary quality. I felt so close to God, so inspired by his spirit that in a sense I was God. I saw the future, organized the universe, and saved mankind. I was both male and female. The whole universe existed within me.” This mystical elated state was transient and
followed by a deep and dangerous depression wherein the urge to kill himself was incessantly forcing itself into consciousness.

One psychodynamic concept of the phenomenology of mania suggests that it can be compared to sleep. It is like the dream of a small child, with the wish fulfillments of the narcissistic pleasure ego. This view postulates that the ecstatic mood state of the manic patient relives the nonverbal experience of union at the mother’s breast and is a defense against the painful frustrations and disappointments of life. One manic patient described her experience thus:

At orgasm, I melt into the other person. It is hard to describe, but there is a certain oneness, a loss of my body in the other person, as if I were part of him without my individual identity, yet in him part of a larger whole. At other times, I am the dominant individual and he the lost one, so that I become the perfect whole—When he seemed to enter me, I gained his attributes, for example, his aesthetic taste, which was better than mine. It seemed as if I absorbed the beauty he made me aware of.

The first part of this description of sexual experience, the sense of oneness with the partner, is within the realm of normal ego regression that may occur in lovemaking. The psychotic element has to do with the second part, where ego boundaries are disturbed and personal identity is lost.

The acutely schizophrenic patient. In contrast to the acutely psychotic patient with mania, whose secondary process is often still functioning, albeit in an accelerated and unrealistic form, the acutely schizophrenic patient may be sullen and withdrawn, mute or stuporous, or posturing bizarrely, or he may appear agitated and incoherent, beset by persecutory auditory hallucinations accusing him of evil and manifesting incoherent speech that makes it difficult for the interviewer to understand what he is attempting to say. In the more cognitively organized, acutely schizophrenic patient, apocalyptic end-of-the-world fantasies are common. This is often a projection of the internal mental catastrophe that has occurred within the patient. Delusional ideas may permeate his thinking. “Now I know what happened to me,” related an acutely schizophrenic patient. “The CIA and the FBI have targeted me because I have special knowledge that will change the world.” This fantasy had the narcissistic function of reassuring the patient that the intrapsychic chaos that had beset him had a purpose, that he was unique and was on a glorious mission. Such defensive fantasies are usually ineffective in calming the patient. They may become crystallized into a rigid and sustained delusional explanation for the sub-
jective experience that has affected the patient. When this fades, the patient becomes more anxious and agitated. Fantasies such as these establish "meaning"—a universal human need—for that which is meaningless and overwhelming, in this case the experience of psychosis. "Why is this happening to me?" is replaced by "This is happening to me because I have a special calling."

**Delusions and Hallucinations**

As noted, delusions, which can occur in both manic and schizophrenic patients, may have a restorative function. They can represent an attempt at psychological repair and provide an explanation for the intrapsychic catastrophe that has occurred. A differentiating point between the delusions found in the manic patient versus the schizophrenic patient revolves around the fixed, crystallized, and unchanging form of delusion found in the schizophrenic patient. This contrasts with the fluidity of delusions in the manic patient, which keep shifting. It almost seems as though the manic patient is making up the delusions as he goes along, and they keep changing in content. One delusion will be dropped as another appears.

The ego defense mechanisms of projection and denial are central to a psychodynamic understanding of both delusions and hallucinations. Freud speculated that in hallucinations and delusions something that had been forgotten in childhood returns and forces itself into consciousness. For Freud, the essence was that there is not only *method in madness* but also a kernel of historical truth—that is, delusions contain, albeit in distorted form, an element of individual history. This formulation is relevant to the interviewer, who should not simply dismiss the delusional structure as "completely crazy" but rather be curious as to what its latent meaning might actually be and what aspect of reality and history relevant to the patient's life is contained in the psychotic elaboration. This may be helpful regarding areas to be explored after the patient is no longer psychotic.

Freud first drew attention to the utilization of the defense mechanisms of denial and projection in delusional formation. (For a more extensive account of Freud's conception of delusional formation, the reader is referred to Chapter 12, "The Paranoid Patient.") Later, Freud acknowledged the enormous role that aggression plays in delusional formation. Further developments in the psychodynamic understanding of both auditory hallucinations and delusional ideas emphasized the projection of the psychotic patient's superego. The persecutor observes and criticizes the patient—that is, the persecutor represents a projection...
of the patient's bad conscience. The patient may feel that he is being controlled, observed, and criticized for his sexual desires, which are depicted as dirty or forbidden. One psychotic patient lamented, "My thoughts are filthy and evil. I will be punished for them by God's retribution. I deserve to be persecuted in Hell for my sexual desires."

Delusions are not all simply persecutory, however. There are hypochondriacal delusions that the body is corrupted and diseased in some fashion, nihilistic delusions that the world has been or will soon be destroyed, grandiose delusions of being the new messiah or a Napoleonic individual who will change the world.

The Schizophrenic Patient Presenting in the Nonacute Phase

Schizophrenia is a chronic disease, and the majority of clinical contacts with schizophrenic patients will occur in the nonacute phase of the illness. Furthermore, many schizophrenic patients have an insidious and gradual onset to their illness. Such a patient does not generally present to the clinician in the acute agitated form described earlier. His withdrawal from the world and increasing social isolation, together with a tendency to conceal delusional ideas, may lead to the illness smoldering unaddressed by a clinician for months or years.

The family members of these patients sometimes collude in a form of denial, ascribing the patient's escalating withdrawn and odd behavior to "eccentricity." In such cases of family denial, help will only be sought when the patient's behavior reaches an intolerable crescendo.

Schizophrenic patients have the same problems and conflicts as neurotic or normal individuals—hopes and fears about family, work, sex, aging, illness, and so on. The schizophrenic person is an individual with an unusual way of thinking, feeling, and talking about the same subjects that all of us think, feel, and talk about. The interviewer can often serve his most valuable function by recognizing this and relating to the patient as a separate and important person.

Disturbances of Affect

The schizophrenic patient may show a disturbance in the regulation and expression of his affect or emotions. The interviewer normally relies on the patient's affective responses as a guide to how the patient is relating to him, and therefore he must adjust to the patient's mode of affective communication. With the schizophrenic patient, subjective emotional experience may be diminished, flattened, or blunted. In ad-
dition, the patient may have difficulty expressing and communicating the emotional responses of which he is aware. More subtle gradations of feeling tone are lost, and the emotionality that does emerge may seem exaggerated. Warm and positive feelings are sporadic and unreliable. The patient somehow fears them, as though his continued independent existence would be threatened if he felt tenderly toward another person. When affection does appear, it is often directed toward an unusual object. A schizophrenic patient may feel positively for his pet or someone with whom he has little real contact or whom others might consider far beneath him in social status. One young adult schizophrenic patient claimed to have no concern for her family but was intensely involved with her cat.

Some schizophrenic patients complain that they feel as though they are only playing a role or that other people seem to be actors. This phenomenon can also be seen in patients with personality disorders. The sensation of playacting results from the patient's defense of emotionally isolating himself in response to a disturbing situation. In this way he remains distant from both his own feelings and those of others. This is common in those with borderline personality. Those with histrionic or antisocial personality may also seem to be playing a role, but this is rarely described by the patient himself; rather, it is an observation of the interviewer, who perceives the patient's false self.

The physical and bodily components of affect may rise to central importance in the schizophrenic patient. These affective components, of course, are present in everyone, although they frequently occur without subjective awareness. The patient will often be fully aware of them but will deny their emotional significance and explain them as responses to physical stimuli. Thus an anxious schizophrenic patient may attribute the beads of sweat on his forehead to the warmth of the room, or a grieving patient will wipe away his tears as he explains that something got into his eye.

The interviewer may find it difficult to empathize or may not trust his own empathic responses to the patient. Affects that he expects to find in the patient do not appear, and the signs that normally help him to understand the patient's feelings are unreliable or denied. A successful psychiatric interview always involves emotionally significant communication, and if the patient appears to have minimal affect, the problem is to evoke and reach this affect while tolerating the patient's level of feeling and avoiding criticizing or challenging the patient's defensive capacity. Some therapists use dramatic or unusual methods to develop an affective interchange with relatively affectless patients. They realize that they must use their own feelings as stimuli before the
patient will permit an emotional interaction to develop. This is preferable to a passive technique of emotional neutrality that allows the interview to unfold without emotion, but the interviewer must constantly monitor the difference between what is being avoided and what is not possible for the patient to acknowledge.

The beginning interviewer is reluctant to use his own feelings in so active a manner. He fears that he will create problems or disturb the patient and is concerned lest he inadvertently reveal too much about himself. He may indeed make mistakes, but if these help to generate an affective interchange where none was present, they may be preferable to a safer but emotionally bland approach.

The patient's feelings may seem inappropriate to the apparent content of his thought, to the interview situation, or to both. However, emotional responses are always appropriate to the patient's inner experience, although this may be hidden from the interviewer. After identifying the patient's emotions, the interviewer's task is to elicit and identify the thoughts that are linked to them. Often the patient has responded to something that seems trivial or unusual to the interviewer. The clinician will better understand the patient if he attempts to unravel the meaning of the patient's reactions as the patient experiences them. The interviewer should not expect customary emotional responses in a schizophrenic patient; the patient may sense this expectation and react by concealing his true emotions. For example, if a social acquaintance spoke of his mother's recent death, the spontaneous response would be sympathy and an indication of willingness to share the experience of grief. The interviewer's response to most patients would be similar. However, this might disturb a schizophrenic patient, because it would indicate that the clinician expected a response that differed from the patient's actual feelings. The patient would then react with evasion and withdrawal, unable to correct the interviewer's error. His true feelings would not emerge. An open-ended inquiry concerning his feelings allows the patient greater freedom in his response.

**Disturbances of Thought**

The schizophrenic patient often has difficulty organizing his thoughts by the usual rules of logic and reality. His ideas may emerge in a confused and bewildering sequence. Every conceivable aspect of organization is potentially defective, as exemplified by loosening of associations, tangentiality, circumstantiality, irrelevance, incoherence, and so forth.

The disorganization of thought and communication is not random. Although the etiology of such difficulties may ultimately be explained
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biologically, the process of disorganization can best be understood in a dynamic framework. Disorganization blurs and confuses, and it appears when the patient experiences emerging anxiety. The patient’s confusion serves as a defense by obscuring an uncomfortable topic.

These cognitive defects have secondary interpersonal effects as well. Circumstantiality and tangentiality are likely to distance and annoy the listener and therefore may become a vehicle for expressing hostility. Gross incoherence and loosening of associations evoke sympathy, although at the cost of emphasizing the patient’s difference from other people and promoting his social isolation. These effects may be exploited by the patient, usually unconsciously. In general, they should not be interpreted early in the treatment because they represent a minimal secondary gain that helps to compensate for a larger primary loss. Later they may become an important source of resistance that must be worked through.

The schizophrenic patient may also have difficulty with the symbolic aspect of language, manifested by his tendency toward inappropriately concrete or abstract thinking. Not only are the connections between words disturbed, but the words themselves may have a different range of meanings than is generally accepted by others and may become important in themselves rather than serve as symbols for underlying thoughts. The patient will frequently interpret the interviewer’s words in a strangely literal way, such as when a patient was asked what had brought him to the hospital and he replied that he had taken the bus. At times the opposite will occur, as when a college student who was acutely psychotic complained of a fear that “My behavior has violated the categorical imperative.” It was several hours before he revealed that he was worried about masturbatory impulses. He had transformed his guilty feelings into ruminations about abstract philosophical systems that deal with right and wrong. By the time he came to see the clinician, it was these philosophical systems, and not sexual thoughts, that consciously preoccupied him. Language functions that are normally autonomous may become involved with sexual or aggressive feelings. Seemingly everyday words are assigned special meaning. One young schizophrenic woman became embarrassed when the word “leg” was used in her presence because she felt that it had sexual significance.

In addition to difficulty in organizing his thinking and in maintaining an appropriate level of abstractness, the schizophrenic patient may accent obscure features while ignoring central issues. For example, a hospitalized man with paranoid delusions who had formerly worked as an attorney became involved in a campaign to get the United States
out of the United Nations, writing letters to the president and members of Congress. At the same time, he was uninterested in resuming his regular employment or even in more traditional political activities. Another schizophrenic patient, a post office employee who had developed asthma, spent several years collecting affidavits attesting to the dust-ridden conditions to which he had been exposed during his employment. His realistic problems with his health, his family, and his occupation were ignored while he pursued a relatively small disability compensation. When his persistence was finally rewarded, he became even more disorganized.

The schizophrenic patient may spend much of his time preoccupied with fantasies that are unusual in content but have special meaning to the patient. If the patient trusts the interviewer enough to reveal them, they can provide valuable insights concerning his emotional life. However, the patient is often afraid to expose his fantasies to others. For the schizophrenic patient, as for any other person, fantasies represent a retreat from reality and an attempt to solve problems by constructing a private world. However, this universal function of fantasy may be less apparent because of the patient's personalized use of symbols and his peculiar style of thinking. Furthermore, he is not sure where fantasy stops. At times his overt behavior can only be understood in terms of his inner reality. The idiosyncratic nature of the fantasy may distract the interviewer from its dynamic significance. In general, the psychotherapeutic exploration of the dynamic origins of fantasies is best deferred until later in treatment, because prematurely focusing on his fantasy life may further impair his contact with reality. The psychological function of the patient's fantasy life is illustrated by the young man who spent many hours planning trips to other planets and developing methods for communication with alien beings. His life on Earth was lonely, and he had trouble mastering the more mundane art of communicating with friends and family.

The schizophrenic patient may develop more complex systems of ideas, entire worlds of his own, if his fantasies are elaborated. When reality testing is intact, these are confined to his mental life, but if the patient is unable to differentiate fantasy from reality, the fantasy becomes the basis of a delusion. Often these ideas are religious or philosophical in nature. As the patient struggles with the nature of his own existence, the struggles are generalized into questions about the meaning of the universe. Religiosity is a common symptom, and schizophrenic patients often turn to studies of religion or existential philosophy before seeking treatment more directly. Less sophisticated individuals may become deeply involved in their church, synagogue, or
mosque, usually with the accent on fundamental questions of theology rather than the daily activities of the congregation. A preoccupation with the existence of God is a typical example. The more delusional patient may have the conviction that he receives messages from God or has a special relationship with Him.

**Disturbances of Behavior**

The chronically schizophrenic patient with prominent negative symptoms may lack initiative and motivation. He seems to not care what happens and is not interested in doing anything, fearing that any activity may reveal him as inadequate or incompetent. His obvious problems seem to distress his family or the interviewer far more than they do the patient himself. Like the apparent absence of affect, the seeming absence of purpose or motivation can provide the patient the secondary gain of avoiding discomfort. However, it often leads to frustration and hopelessness in others, further increasing the patient's isolation. At times the interviewer can overcome this defense by searching for those areas in which the patient remains capable of acknowledging involvement and, at the same time, exploring the fears that inhibit his interest in other aspects of his life.

**Disturbances in Interpersonal Relations**

The chronically schizophrenic patient may have difficulty relating to others. Dynamic psychotherapy utilizes the exploration of transference as a major tool in helping the neurotic patient to understand his conflicts and to modify his patterns of behavior. This assumes that the patient has a simultaneous nonneurotic relationship with the doctor that allows him to look at his transference feelings objectively. It was once thought that the schizophrenic patient did not establish a transference relationship and therefore could not be treated by psychodynamic psychotherapy. In fact, he often establishes an intense transference quickly, but the resulting feelings may threaten the basic alliance between patient and therapist. The greatest problem is thus to maintain the therapeutic alliance, and in view of this, interpretations of the neurotic origins of the transference must be focused on those that enhance the therapeutic alliance.

A close relative of the schizophrenic patient frequently seeks professional help for the purpose of better understanding a daughter, son, or spouse:

A man in his early 60s had a chronically schizophrenic son, age 40. He complained to his consultant that he had invited his son to a fine restau-
rant. The son had attempted to be appropriate in order to please his father, who then scolded him severely for wearing a pair of dirty sneakers with his blue suit. The man added that he felt embarrassed and humiliated by his son’s behavior. The consultant asked how he understood his son’s behavior. He replied, “He did it to annoy me. I told him it was a dressy place and to wear a suit. Do you think I was too hard on him?” The interviewer replied, “Your son has no job or other connection to the world into which he was born except through you. He tried to please you, but he felt alienated from himself, disguised as a normal person. Those dirty sneakers are a reflection of his inner identity.” The father appeared shaken and asked, “Is there something I can do to fix the pain that I caused him?” “Yes,” the interviewer replied, “you can apologize to him and share your enlightened understanding of his dirty sneakers and ask him to dinner again.” Two weeks later, he again invited his son to the restaurant, this time with no instructions. His son arrived in the same blue suit but wearing a brand-new pair of sneakers. The interaction led to a moving exchange between father and son.

Assertion, Aggression, and the Struggle for Power and Control

The schizophrenic patient sometimes harbors hostile and angry feelings that he experiences as overwhelming. The patient is anxious lest these hostile feelings emerge and he be allowed to destroy others. He usually suppresses his healthy assertive capacity along with his violent rage. His judgment is often poor in evaluating both his destructive potential and his ability to control it. Although excessive inhibition is the usual result, there are times when his fear seems well founded, and he may be capable of violence. Therapy attempts to develop his awareness and integration of both his inner hostility and his controls without forcing him into premature and frightening assertive behavior. One patient was unable to obtain a driver’s license because he could not tolerate the frustration and resulting rage at having to wait in line, and he was fearful of his inability to control his responses. Months later he deliberately rammed his parents’ car into a number of parked vehicles at a supermarket, creating a scene that resembled a demolition derby.

Suicide and Violence

Suicide is an ever-present danger with the psychotic patient. Suicide is the leading cause of premature death in both schizophrenic and psychotic bipolar patients. A careful inquiry into suicidal ideation is crucial in the interview, because the presence of suicidal ideation has been shown to be predictive. Most psychotic patients do not spontaneously report suicidal ideation, and the clinician must be active in the interview about inquiry into its presence and pervasiveness in the patient’s mental life. This can be approached tactfully: “You have been so upset;
I wonder if sometimes you don’t think that life is not worth living?” If the patient responds by saying, “I do sometimes think it would be better if I weren’t around” or some equivalent that may be euphemistically expressed—for example, “I’m such a burden” or “Life is such a torment”—this should precipitate more direct inquiry by the interviewer into how suicide would be effected. If the patient reveals a thought-out plan, this should alert the interviewer to the fact that suicide is an imminent danger. The concomitant presence of depressive symptomatology—“The world is empty”; “I’m such a failure”; “Nothing has any meaning”; “I have no pleasure in life”; “It all seems worthless”; or “My situation is hopeless”—is also a red flag to the interviewer that suicide is a real possibility.

Command hallucinations to kill themselves or harm others are critical indicators for potential suicide or violence in schizophrenic patients. Although only a small minority of schizophrenic patients are violent, schizophrenia is associated with an increased risk of aggressive behavior. Some schizophrenic patients may act on their paranoid delusions, and the interviewer should not only empathically explore the nature of the patient’s delusions but also ask whether he is tempted to take action against those whom he feels are harmfully investigating him or whom he feels are persecuting him.

**Comorbidities**

The most common comorbidity in schizophrenia is substance abuse. Schizophrenic persons have six times the risk of developing a substance abuse disorder that the general population has. It is possible that the attraction to mind-altering substances is predicated on a desire to control and change the painful mental state that the schizophrenic patient often endures. However, the use of such substances can precipitate exacerbations of the disorder, and the interviewer should carefully investigate the patient’s use of drugs and alcohol, which when regularly abused indicate specific treatment.

Both alcoholism and substance abuse are common comorbid conditions in bipolar illness. Substance abuse may exaggerate mood states or precipitate acute episodes, and careful inquiry should be made by the interviewer concerning the bipolar patient’s use of these agents. The combination of alcohol or drug abuse with bipolar illness can be particularly deadly, and the clinician must monitor this issue with great care. When the bipolar patient slides into the depressed side of the disorder, the use of alcohol or sedatives as self-medication can easily lead to overdose and death.
MANAGEMENT OF THE INTERVIEW

It may be difficult to establish emotional rapport with a psychotic patient, but as with any other patient, this is the primary task of the interviewer. The patient’s intense sensitivity to rejection may lead him to protect himself through the use of isolation and withdrawal. In most psychiatric interviews the patient is encouraged to reveal his conflicts and problems with as little intervention as possible from the interviewer. The clinician serves as a neutral empathic figure who recognizes the patient’s needs but does not gratify them directly and who avoids becoming involved in the patient’s life outside the sessions. The interview with a psychotic patient requires modification. The patient feels rejected if the interviewer merely recognizes his needs. It is necessary for the clinician to convey his understanding more actively by expressing his own emotional response or by providing symbolic or token gratification for the patient’s needs.

Should the psychotic patient ask the interviewer to recommend a coffee shop near the office, the therapist should answer directly and provide the information without further interpretation. With a neurotic patient, on the other hand, the therapist might provide the information and also register and possibly interpret the unconscious wish incorporated in the patient’s request, for example, a wish for dependency gratification or for the avoidance of more meaningful material. In the early phase of work with the psychotic patient, the clinician accepts whatever limited emotional contact is possible. The patient will accept gratification from the therapist only on his own terms. The therapist should accept these terms as the basis for the initial relationship as long as they are within the realm of reality.

Prior history of psychiatric hospitalization, medication, and other treatments are an important area of inquiry. This includes dates, duration of hospitalizations, and names and dosages of medications. A history of side effects is also crucial, because these are the major reasons that patients do not comply with a treatment plan. An encounter illustrating this occurred some years ago when a colleague consulted one of us regarding a patient with chronic schizophrenia who seemed to be re-experiencing psychotic symptoms:

The author listened to the story and suggested that he was the wrong consultant and that it sounded like the patient should consult a psychopharmacologist. The colleague persisted: “You are the right person to see this patient.” The author accepted the request only to learn after the first 15 minutes of the interview that the patient had secretly discontinued
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her medication because of unpleasant side effects. The consultant remarked to the patient in a warm tone, “You like Dr. A, don’t you?” “Very much,” the patient replied. The interviewer continued: “You wouldn’t want to disappoint him, would you?” The patient appeared sad and outpoured her confession of discontinuing her medication. The interviewer asked her permission to report his findings to Dr. A in a manner that he was certain would not hurt Dr. A’s feelings and told her that Dr. A would help her further with this problem. She had lied to her psychiatrist because “He is so nice, and I know he cares about me and wants to help me, but I didn’t want to hurt his feelings by rejecting his medication.” This revelation opened an important area for psychotherapeutic exploration and interpretation. In a jocular tone, the consultant showed his report to his colleague. “I told you that it sounded like your patient had a medication problem,” he said. The treating doctor replied, “I told you that you were the right consultant.” This is not a unique or even unusual experience working with bipolar or schizophrenic patients.

The Acutely Psychotic Patient

Although the acutely psychotic patient may sometimes present in the clinician’s office after making a scheduled appointment, many are encountered in the emergency department, where they are often brought by family, friends, or social agencies.

The patient’s agitation, fueled by his acute anxiety, is often the most prominent clinical feature and requires both somatic and psychological interventions. The interviewer’s most important psychotherapeutic intervention during this acute phase is that of providing psychological support and a “container” for disruptive affects—what amounts to an external ego for the patient. The patient’s reality testing is often fragmented, and the interviewer, by adopting a calm, measured, empathic approach, can provide an external psychological structure that helps to mitigate the patient’s sense of internal chaos. The interviewer has to self-monitor the danger of being “infected” by the patient’s rampant anxiety. He must soberly assess the patient’s potential for violent or self-destructive behavior. In extreme cases, external restraints may be necessary to prevent the patient from violent outbursts, elopement, or attempts to commit suicide.

When the acute, agitated phase has subsided, the interviewer can begin an exploration of the precipitating event. What factors, intrapsychic or contextual, triggered the onset of the illness? A careful inquiry into drug use should be made, from the patient if possible or from family or friends, because many agents—such as cocaine, methamphetamine, and phencyclidine—can induce an acute psychosis. The interviewer must sort through the chaos of the patient’s acute psychosis to
discern the sequence and role of events, conflicts, and symbolic or real losses that may have led to the acute illness. The psychotic patient may possess a biological diathesis for the disease, but environmental precipitants are usually involved in onset or acute exacerbations. An example is the acutely psychotic young adult who stated wistfully, “I’m due to be married in 2 months. Maybe this is making me crazy. Marriage scares me, even though I love my fiancée.” This patient was indeed terrified of this developmental step. Each developmental milestone involves losses as well as gains. In this patient’s case, the loss was that of being an adored child with omnipotent parents who would always protect him. He was torn between the desire to be a child and his attraction to his fiancée and wish to be grown-up. This conflict, combined with genetic vulnerability, had indeed driven him “crazy.”

Careful inquiry into the nature of the patient’s delusions can be very productive in understanding both acutely and chronically schizophrenic patients. A delusion provides special access into getting to know the patient because it embodies his core wishes and concerns. The delusion is a special creation, much like the dream, which in Freud’s words is “the royal road to the unconscious.” For the patient, the delusion explains everything. It is not a false belief, a universal phenomenon in normal human psychology, but a defensively held, fixed belief system that is clung to in spite of evidence to the contrary. The interviewer should not argue with the patient about the irrationality of the delusion but be curious as to its content and larger meaning for the patient. It is a creation with significant individual meaning.

The bizarre behavior of a regressed, acutely psychotic patient has a disconcerting effect on most interviewers. The patient may sit on the floor in the corner of the room, holding his coat over his head, or constantly interrupt the interviewer to converse with a third, but nonexistent, person. The interviewer can help this patient to control such behavior and promote rapport by indicating that he expects something different. If the behavior does not annoy the clinician, he might say, “Are you telling me that someone considers you to be crazy?” Another interviewer might sit on the floor in the corner with the patient. This indicates that the interviewer is neither impressed nor intimidated by the patient’s behavior. If the clinician is annoyed, it is best to first explore the hostile or provocative aspect of the patient’s behavior. The impact of the mental health practitioner communicating his expectations is illustrated by the clinician who was called to the emergency department to see an acutely psychotic patient who was standing in a corner and shouting at the staff, “Repent of your sins... Jesus saves!” The clinician interrupted the patient and said, “You’ll have to sit down here and stop screaming for a few
minutes if we are going to talk.” The patient responded promptly to the interviewer’s expectation of normal social behavior.

The patient’s behavior may include inappropriate demands upon the interviewer. A patient may enter the office and, without removing his overcoat and two sweaters, ask that the interviewer turn off the heat and open the window because he may become overheated and then catch a cold when going out-of-doors. The interviewer is well advised not to comply with such unrealistic demands. In exploring the content of a delusional system, the interviewer may ask questions concerning the details of the delusion as though the delusion were reality. In taking a genuine interest in the content of the patient’s delusions, it is important that the interviewer not suggest that he believes them. In the case just mentioned, the interviewer could ask the patient if his mother used to caution him about catching cold when he went out-of-doors in an overheated state. If the inquiry is productive, the clinician could inquire about what feelings accompanied the experience.

If the patient exhibits destructive behavior, the interviewer should stop the patient from doing damage to the interviewer’s or the hospital’s property, because it is not helpful to allow a patient to infringe on the rights of others. The patient who is permitted to continue such behavior will often become ashamed and guilty when he is less psychotic and will justifiably be angry with the clinician who did not supply the needed controls.

Development of the Therapeutic Alliance

The most common problem encountered in the interview with the psychotic patient involves the consequence of his inner disorganization. Furthermore, the psychotic patient’s difficulty in organizing his thinking can be used defensively to avoid communicating with others. For example, a psychotic patient may speak freely from the beginning of the interview, manifesting little anxiety or hesitation; however, the interviewer soon encounters difficulty in following the trend of the conversation. The patient starts to answer a question but then leaves the topic. The interviewer may respond with confusion, boredom, or irritation. Often he does not recognize that the patient has changed the subject until the patient is in the middle of a new topic. On other occasions, the patient may seem to adhere to the topic under discussion; his words and even his sentences make sense, but somehow they do not fit together. This disorganization tests the interviewer’s interest and attention and serves to block effective communication. The interviewer must reveal his difficulty in understanding the patient rather than respond-
ing, as in most social situations, with feigned understanding and concealed boredom, eagerly anticipating the termination of the contact. He can support the patient by avoiding statements that tend to berate him or that suggest that he is responsible for the interviewer's lack of understanding. Rather than saying "You're not making yourself clear," the interviewer can say, "I'm having difficulty following what you are saying." Similarly, "I don't understand how we got on this subject" is preferable to "Why do you keep changing the subject?"

Although it may be possible to understand the content of the disorganized patient's communication, it is nevertheless important to deal with the process of disorganization and its effect upon the developing relationship between the interviewer and patient. The long-term goals of treatment include helping the patient to communicate more effectively with other figures in his life as well as with the therapist.

Disorganization is sometimes apparent within the first few moments of the interview. The patient may be unable to describe a chief complaint. He might say, "I haven't been feeling too well lately" or indicate that one of his close relatives thought that he should come to see the clinician. One young man came to a hospital emergency department late at night asking to see a psychiatrist but was unable to formulate any specific problem; he simply stated that he was upset. His waxlike face and vacant stare suggested a psychotic illness. When the clinician directly inquired about his current life, he revealed that he had just come back from a business trip and had discovered that his wife had taken their small child and left him. He felt panicky and helpless, but in his own mind he did not connect these feelings with the traumatic events that he had just experienced.

When a patient answers the interviewer's opening inquiry with a vague reply, it is helpful to inquire whether the patient himself decided to consult a clinician. If the patient indicates that it was not his own idea, the interviewer can explore why another person felt that such a consultation was indicated. Furthermore, the interviewer might inquire whether the patient felt he was "dragged against his will" or pressured to come. Sympathizing with the patient's resentment concerning such a process facilitates early rapport.

The interviewer might then inquire if this is the first time that the patient has consulted a clinician. If not, prior contacts are carefully explored. In discussing previous psychiatric contacts, explicit inquiry about past psychiatric hospitalization is important. Psychotic patients often indicate that there have been prior hospitalizations but seem unable to describe what led to them. The interviewer could ask about the circumstances of the hospitalization and inquire about the symptoms.
It is appropriate to inquire about a previous history of secondary symptoms with every grossly psychotic patient. While making these inquiries, the interviewer communicates his interest in understanding the patient rather than his interest in establishing a diagnosis. For example, instead of merely asking the patient if he heard voices, the interviewer would go on to ask what they said, how the patient interpreted them, and what he felt had caused these experiences. If the patient does describe the symptoms of previous psychotic episodes, the interviewer can inquire about their recurrence in the present. With regard to delusions, the interviewer should inquire as to what the belief is, how systematized and elaborated the delusion is, how the patient feels other people view his convictions, and how certain he is of his delusional conviction.

The clinician actively assists the psychotic patient in defining problems and focusing on issues. This is true even for the patient who does not have a serious disorganization of thought processes. Despite such efforts, some patients remain unable to identify the problem that is the theme for the interview. The interviewer can help by pursuing specific precipitants of the request for consultation. Questions such as “What was the final straw?” or “Why did you come today rather than last week?” may be helpful. It is also valuable to inquire about the patient’s expectations of the interview. For example, if he communicates that he has difficulty finding a job, the interviewer attempts to pinpoint the specific difficulty encountered. The interviewer can gradually shift the focus from the external environmental problem to the intrapsychic issues. Often this will involve interpretive comments concerning precipitating stresses in the patient’s current life. As an illustration, the interviewer might say, “Your trouble at work seems to have started at the time that your wife became ill. Perhaps this upset you in some way?”

It is easy to overlook the adaptive skills of psychotic patients. In focusing the interview, the clinician should direct attention to the patient’s assets and areas of healthy functioning as well as to his pathology. The emphasis of the interview thereby shifts from exposing the patient’s deficiencies to supporting his attempts to cope with the stresses in his life and the conflicts within himself. This also involves an evaluation of the patient’s living situation. With whom does he live? What is the nature of their relationship? Can the patient take care of himself, pay the rent, cook meals, take his medication? What has he done recently that he enjoyed? What are his interests?

The interview may seem to be rambling or aimless despite the interviewer’s attempt to provide structure. In this situation, the interviewer looks for topics and themes that recur repeatedly, even though they
may not occur sequentially in the interview. Thus, the interviewer might say, “You keep coming back to the trouble with your boss. I guess it is on your mind.” Even if the interpretation is inaccurate, this comment indicates an interest in searching for the meaning of the patient’s thoughts rather than treating them as incoherent productions. Accuracy is only one determinant of the effect of any interpretation. Timing, tact, and the transference meaning of the interpretive activity are all important factors that influence its impact on the patient. The patient can be helped by observing how the interviewer tries to determine what is happening regardless of whether the attempt is successful. In addition, the therapist tries to demonstrate that he is interested in understanding rather than judging or condemning. Accuracy becomes increasingly important as a patient learns to trust the therapist and to use the insights that he gains in therapy. This process is particularly slow with psychotic patients, and therefore it is an error for the therapist to refrain from interpretive activity early in the treatment because he is not sure what is happening. If he is open about his uncertainty and invites the patient to join him in a search for meaning, the development of a therapeutic alliance will be fostered even if he is wrong in his interpretation. Phrases such as “I’m not sure I fully understand what has been happening here, but it seemed to me…” or “I’m sure that this is only part of it, but could it be…” are helpful.

As the patient becomes better acquainted with the clinician, he may reveal a surprising degree of insight into the social significance of his disorganized thought processes. For example, one young woman explained that when another person would nod in agreement even though she knew that the person did not really understand her, her communication would become even more diffuse and incoherent.

Some patients express acute emotional turmoil in association with the disorganization of their thought processes. The interviewer first works with this patient’s feelings. He utilizes any communication that seems related to the patient’s overall feeling tone and links it to the emotion the patient displays. For example, an agitated, disturbed young woman appeared in the emergency department of the hospital muttering incoherently. The interviewer empathically inquired about what she was muttering, stating that if he could hear her words, perhaps he could understand what was happening to her. She became more coherent and revealed that her husband had just abandoned her and that she was laying a “curse” on him so that he would die a terrible death because of his cruel behavior toward her and their children. She calmed down considerably after she revealed this.
ROLE OF THE CLINICIAN

The patient’s disturbance of affect leads to an extension of the clinician’s traditional role. The patient may be better able to express his emotions in response to some similar expression on the part of the interviewer. Therefore the interviewer follows the patient’s emotional cues and utilizes them to develop the affective tone of the interview. These cues may be difficult to detect, and the interviewer may have to be active in helping the patient both experience and express his own feelings. He may directly inquire if the patient is experiencing some particular feelings, asking, for example, “Are you angry right now?” The patient will often respond to such interventions with a total denial of any feeling similar to that suggested by the interviewer. After acknowledging that he may have been wrong, the interviewer can then discuss his difficulty in determining the patient’s feelings. This will lead to an examination of the motivational aspects of the patient’s defenses against feeling rather than to an argument about who knows more about the patient’s inner mental state. If such an exploration is premature, the interviewer can let the subject rest. It is common for a psychotic patient to vigorously deny a response suggested by the interviewer and then, weeks or months later, refer to the episodes as though he had been in complete agreement.

There are occasions when the interviewer has no idea what the patient is feeling and the interview seems dull and flat. Flatness and the lack of interaction reinforce the patient’s sense of loneliness, isolation, and alienation. The interviewer might utilize his own emotional response in such situations as a guide to the further conduct of the interview. To illustrate, the interviewer could say, “As I listen to your description of your life, a sense of boredom and loneliness comes through. Perhaps you have similar feelings?” or “It sounds as if your life feels purposeless and filled with meaningless detail. Was there ever a time when it was different?”

When the treatment has progressed sufficiently, the clinician may modify his role in other ways. For example, a patient might come into the office and comment, “It’s a beautiful day outside.” The clinician who has developed a stable positive relationship with the patient might agree and add, “Shall we go out for a walk?” The spontaneous suggestion of a change in routine may open up areas of rigidity in the patient, expose fears about obtaining forbidden pleasure, or initiate a discussion about his perception of the therapist as a real person. If the patient is able to accept such contact with the clinician, an opportunity is pro-
vided for sharing a new experience. The therapist must feel comfortable before making such a suggestion or the patient may perceive and interpret his discomfort as indicating that the therapist is ashamed to be seen with the patient in public. In the situation just described, the patient responded to the clinician's suggestion by stating, "You probably have colleagues in this neighborhood. Suppose one of them saw you walking with me?" The clinician responded, "So, then what?" "They would wonder what you were doing walking with this bag lady." This interchange led to a productive discussion while they walked.

Interpretations of the Defensive Pattern

With the ego's weakened capacity for repression, the psychotic patient may reveal unconscious material in the initial interview that would take months to uncover in a neurotic patient. The beginning interviewer is often intrigued by hearing the patient discuss conflicts that are normally unconscious in the same terms that appear in a textbook. However, the patient's intellectual insight into the unconscious is not to be encouraged, because it is a manifestation of basic psychopathology. The psychotic patient may sense that the clinician has become intrigued and might continue to produce such material in order to maintain his interest. The interviewer can best respond to such productions by asking the patient if he was helped by his attempt to understand his "Oedipus complex" or whatever other term the patient may have used. If the patient indicates that he was not, the interviewer can ask why the patient wishes to discuss the topic or suggest that they direct their attention to some other area that might be more helpful, while recognizing that the patient is trying to be cooperative with the therapy.

It is valuable to explore the minute details of day-to-day living with the psychotic patient, because it is his difficulty with these aspects of life that drives him to a defensive retreat and a world of his own. For example, a young psychotic woman came to the session after a shopping expedition that left her quite depressed. She was silent for the first 10 minutes, but with the clinician's encouragement, she related her conversation with the salesperson, and it became apparent that she had been coerced into buying something that she did not want because of her guilt about wasting the woman's time. She had been quite unaware of her response, or of her anger and withdrawal that followed it, and had felt only a sense of gloom. However, she was able to report the events in detail, and with the therapist's help, she reconstructed and reexperienced her emotional responses as well. Patterns such as this will require multiple new experiences of a similar nature before the
patient can acquire the psychological template required to extinguish
the old way.

On some occasions, the clinician's successful understanding of some
aspect of a patient's private fantasy life may intensify the patient's fear
of having his mind read and of losing his identity. The patient may re-
treat to a defensive posture, and his communication may become more
obscure. It is important that the clinician then acknowledge his inability
to understand, because this will reassure the patient that he is able to
establish a separate identity and that he will not fuse into oneness with
the interviewer.

A seriously disturbed young woman had developed a strong positive
tie to her therapist after several years of work. One day she presented a
dream, an unusual event in the treatment, that concerned her anger at a
grade-school teacher who had paid less attention to her than to her
classmates. As was characteristic, she had no associations. The therapist
intuitively understood the dream as soon as he heard it, recognizing its
transference implications and relating them to an attractive woman
whom the patient had seen in his waiting room the preceding day. He
told the patient his associations, and she was silent for some minutes.
She then said that she thought that dreams were meaningless anyway
and that was why she rarely discussed them. Over the next few months,
she became increasingly guarded and evasive, until she finally quit
treatment. Certainly this single episode was not the only cause, but it
came to symbolize her fear that therapy represented a threat to her per-
sonal integrity and that as long as she was a patient, she could not main-
tain her personal boundaries.

The interviewer will be more successful if he attempts to see the
world as it appears through the patient's eyes. In order to accomplish
this, he must be prepared to share the patient's loneliness, isolation, and
despair. The psychotic patient may evoke feelings of confusion and
intense frustration in the clinician. It is often helpful if the therapist
admits to the patient that he is experiencing such emotions and inquires
whether the patient is experiencing similar feelings.

Ancillary and Ongoing Treatment

Although clinical research has dispelled pernicious notions of psycho-
sis originating as a result of pathological parenting, there is consider-
able evidence that concurrent family interventions are useful. Psycho-
educational family treatment efforts emphasizing emotional, empathic
support for the patient while acknowledging the frustration, anger, and
guilt that the family may experience in their dealing with him are
directed at helping the psychotic patient's family deal with a debilitating illness. Simultaneously, the clinician has a crucial role in fostering and preserving a therapeutic alliance with the patient. Such an alliance helps to maintain medication compliance and makes the patient a partner in recognizing early exacerbations of the illness that require active psychopharmacological intervention. Helping patients develop insight into their illness, its reality, its meaning, and its value in understanding themselves and their conflicts can be highly therapeutic. For the patient with chronic psychosis, small gains in everyday functioning should be acknowledged and applauded by the clinician.

CONCLUSION

The clinician's psychotherapeutically supportive, consistent, and emotionally constant individual involvement with the psychotic patient—an approach that is sensitive to both psychodynamics and the crippling impact on self-esteem that psychosis causes—can be of crucial healing benefit. This was eloquently expressed in a written account by a schizophrenic patient:

Can I ever forget that I am schizophrenic? I am isolated and I am alone. I am never real. I playact my life, touching and feeling only shadows. My heart and soul are touched, but the feelings remain locked away, fester inside me because they cannot find expression.... One of the hardest issues for me to deal with has been trust. My mind has created so many reasons to fear the real world and the people in it that trusting a new person or moving to a new level of trust with a familiar person presents a terrifying conflict that must be hammered out over and over until I can find a way to overcome my fears or in a few cases give up the battle, even if just for the time being. The intensity of this conflict makes it hard to build relationships. It's hard for the family to help. It's difficult for them to understand the nature of the disease. Therapy with schizophrenics can go for years before a level of trust is built up sufficiently for the patient to use his therapist as a bridge between the two worlds he is confronted with. For me, each new experience of trust adds a new dimension to my life and brings me that much closer to living in reality.