The Primacy of Psychoanalytic Intervention in Recovery from the Psychoses and Schizophrenias

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Abstract: Functional capacities, such as attachment and affect regulation, object relations capacity, symbolic function and language development, now documented by neuroscience research and epigenetics, are reviewed. Results from this research, together with other factors, are posited to have contributed to effective contemporary psychoanalytic and psychotherapeutic treatments for the psychoses and schizophrenias. Etiological factors involving the schizophrenias and other psychoses are considered both in terms of an epigenetic model, and in terms of how etiology may, or may not, affect clinical treatment. The Lacanian 388 program is reviewed in some detail, as are several psychoanalytic and psychotherapeutic clinical approaches used with this population over the last six decades. All treatments focus on the primacy of psychotherapeutic intervention, and use medications minimally, not at all, or only as informed by an overarching psychodynamic model of treatment. The author argues that there is now substantial research and outcome data suggesting that the psychoses and schizophrenias are not chronic deteriorating conditions. Recovery is observed in many psychotic and schizophrenic patients treated with approaches that focus on the primacy of psychotherapeutic intervention.

The functional capacities observed by early psychoanalysts, such as the development of the defenses and the ego, language development and symbol formation, and affective and object relations capacities, have now been documented by contemporary findings in the areas of neuroscience and epigenetics. Research in the areas of attachment, object relations capacity, affect regulation, language and cognitive develop-
opment, and trauma, will be reviewed. Referring to this research and clinical work, I posit several factors that have contributed to the development of effective contemporary psychoanalytic and psychotherapeutic treatments for the psychoses and schizophrenias. Etiological factors involved in the schizophrenias and other psychoses will be considered both in terms of an epigenetic model, and in terms of how etiology may, or may not, affect clinical treatment.

Worldwide, psychoanalytic psychotherapies, family therapy, and community support are showing much greater recovery rates for both the psychoses and schizophrenias than treatments in the United States that focused on long-term medication-only treatment (Alanen, 1997; Apollon, Bergeron, and Cantin, 2002; Berke, Fagan, Mak-pearce, & Pierides-Müller, 2002; Davidson, 2003; Gottidiener & Haslam, 2002; Pepper, 2005; Ver Eecke, 2003). Programs of treatment that focus on psychological approaches as primary, sometimes also combined with medication, have yielded outcomes superior to treatments focused on long-term medication use. Especially in young people with a first time psychotic break, medication is increasingly seen as a temporary and optional benefit, and not required life-long (Alanen, Lehtinen, Lehtinen, Aaltonen, & Räkköläinen, 2000; Mosher, 2004). I will provide evidence that substantiates the following: The psychoses and schizophrenias are no longer universally seen as chronic deteriorating conditions; recovery is observed in many patients receiving treatments that focus on the primacy of psychotherapeutic intervention.

Before examining these various treatment approaches focused on psychotherapeutic intervention and recovery, the confluence of factors across disciplines, research, and cultures that I believe laid the groundwork for these psychotherapeutic approaches will be outlined.

1. CONTEMPORARY ATTACHMENT RESEARCH, TRAUMA THEORY, AND POSTTRAUMATIC STRESS DISORDER (PTSD) RESEARCH

Attachment Theory and Affect

Research has demonstrated that the infant’s early interactions with primary caregivers contribute greatly to the development of long-term emotional health. Peter Fonagy, and Allan Schore, both psychoanalysts and researchers, have been at the forefront of providing research that demonstrates the importance of a secure attachment in laying the groundwork for later complex affective and cognitive abilities. Neuroscientific research has demonstrated that impaired attachment is
associated with neurological and cognitive deficiencies and affective dysregulation in childhood and adulthood (Fonagy, 2001; Schore, 2001). Early attachment experiences involving interpersonal interactions between child and caregiver, then, molds the purely biological drives into complex cognitive and affective functions. The attachment sequelae are observable both in terms of the neurological structures and neurochemical status, and the functional capacities of the developing child and later adult (Aron & Anderson, 1998; Decety & Chaminade, 2004; Gerhardt, 2004; Paquette et al., 2003; Schore, 2001). Secure attachment has been found to contribute to the development of personality characteristics such as the ability to trust, the capacity to empathize with others, the capacity to regulate affect and self-esteem, and the capacity to relate to others in a complex and mature manner.

Teixeira (1997) cites several studies demonstrating that children with attachment insecurity are less competent interpersonally, and have lower self-confidence and ego resilience. Teixeira found that both mothers and fathers can contribute, though differently, to an insecure mother–child attachment. The importance of attachment is reflected in the findings of a NIMH study that analyzed the attachment of two- and three-year-olds of mothers with bipolar, major, and minor unipolar depression, and nonpsychiatric control mothers. The study concluded that the mothers’ expressed emotion predicted patterns of attachment independent of diagnosis, and that the absence of the father increased the risk of insecure mother–child attachment for mothers with major affective disorder (Radke-Yarrow, Cummings, Kuczynski, & Chapman, 1985).

**Separation, Loss, and Insecure Attachment**

One of the primary frustrations of normal infancy and childhood—and of life—is that of separation and loss. At these critical moments of separation and loss, which can never be predicted, nor entirely avoided, the child or later adult is always at risk. The vast majority of psychotic and schizophrenic individuals have had some experience of a disrupted attachment, evidenced by the schizophrenic’s pathological symbiotic attachment style (Benedetti, 1987; Searles, 1965, 1979). This pathological symbiotic attachment style is interesting to consider in light of Lacan’s theory of psychosis. Lacan identifies the failure of the role of the father (“the Name of the Father”) to indoctrinate the child into the use of symbols (“the Symbolic Order”), and break the early maternal symbiotic attachment, as contributing to the child’s later psychotically organized character (Lacan, 1993, pp. 193-213). With an inadequate at-
Attachment experience, these individuals are particularly vulnerable to loss and separation, and thus lack the ability to maintain emotional stability and self-cohesion at these times.

Harold Searles is a psychoanalyst whose work is unparalleled in the psychoanalytic treatment of schizophrenic patients. Searles spoke of the schizophrenic’s often constant experience of the “inevitability of death.” The terror involved in living with the emotional certainty of one’s own death is central to many other psychoanalytic conceptualizations of psychosis within the existential and object relations schools. These theories, unlike Freud’s theory of etiology for both the psychoses and neuroses, do not give libido theory and oedipal problems prominence. Instead, the terror of death in the schizophrenic, together with a pathological symbiotic attachment pattern and experience of the self, makes the subjective affective experience of the schizophrenic unbearable, resulting in the eventual retreat into psychosis.

Death is the ultimate experience of loss and separation. Persons developing psychosis or schizophrenia have been found to be particularly vulnerable to experiences of loss and separation, related to developmental deficits that go back to the earliest experiences of attachment. Searles’s work has helped us understand the importance of dealing with the schizophrenic’s constant experience of terror. Psychoanalysts hold that only by working through these unconscious intense affects, such as terror and rage, can the individual integrate the split-off unbearable affective experiences, instead of being trapped in repeating and living through them (Bion, 1957, 1959; Coltart, 2000; Daniel, 2004; Eigen, 1986, 2002; Gibbs, 2004, 2007; Kavanagh, 2003; Klein, 1946; Pick, 1985; Searles, 1979; Steiner, 1993). Contemporary psychoanalysts have noted that poor early attachment and affective development is correlated with a later vulnerability to loss and separation, in persons described as falling in the range of borderline and psychotic adolescent or adult functioning (Blos, 1967; Fonagy, 1998; Kernberg, 1984; Krystal, 1988).

Developmental Sequelae—Language and Self Fragmentation

Related to this attachment research are theorists, such as Gregory Bateson (1972), R. D. Laing and Esterson (1964), and Virginia Satir (1967), who identified particular communication patterns in schizophrenic patients and their families, based on what is called “the double bind.” Essentially, communications involving double bind processes can be summarized as those in which the communicating person comes away with a profound feeling of: “I can’t win—no matter what I say.”
This experience is, over time, deeply embedded in the emotional experience of the self, with the self being riddled with a sense of wrongness, alienation, and fragmentation. In the schizophrenic person, the fragmentation often observed in typical cognitive processes, especially incoherent and fragmented speech, was gradually understood to be based, in part, on the developmental deficits related to insecure attachment.

It is my observation, as well as that of others (Aderhold & Gottwalz, 2004; Fromm Reichmann, 1959; Karon & VandenBos, 1996; Read, Goodman, Morrison, Ross, & Aberhold, 2004a; Read, Seymour, & Mosher, 2004b, Sullivan, 1962) that the schizophrenic person, having an insecure attachment experience, and ongoing difficulties with normal separation–individuation developmental tasks, is particularly sensitive to intrafamily conflict. The ongoing developmental sequelae of insecure attachment, and sensitivity to family dynamics, then, in combination with other factors is associated with fragmented speech patterns of the schizophrenic, and the schizophrenic family.

These splitting and fragmentation tendencies had been identified by Wilfred Bion as early as 1953, and intensely studied by Silvano Arieti (1974) in his seminal work, *Interpretation of Schizophrenia*. Language and family dysfunction have long been observed by clinicians in psychotic and schizophrenic patients and their families, and is now being validated by neuroscientific and epigenetic research, which will be reviewed shortly.

**Trauma Theory, Dissociation, and PTSD Research**

Experiences of overwhelming trauma, such as exposure to war, rape, or violence, often have a specific aftermath. The symptoms associated with Posttraumatic Stress Disorder, or PTSD, such as flashbacks, affective blunting or volatility, nightmares and sleep disturbance, and dissociation of the traumatic event, have all been observed to be similar to the behavioral manifestations of a psychotic episode. Contemporary trauma work and PTSD research has added to our understanding of the importance of talking about terrifying experiences, and in the case of psychotic or dissociative patients, talking about hallucinations and delusions within the safety of a transference relationship. The occurrences of affective blunting, fragmentation, dissociation, and projection, shared by PTSD and psychotic patients, have been found to be quite responsive to psychotherapeutic and psychoanalytic interventions based on an understanding of affective containment, splitting, and projective identification, now long used by contemporary psychoanalysts (Boyer &
Psychoanalysts and psychotherapists working with dissociative patients, including Dissociative Identity Disorder (DID), have contributed to treatment approaches that have overlapped with the effective treatment of psychotic individuals. Research in this area shows that trauma and abuse are highly correlated with the dissociative disorders (Putnam, 1989). In severely dissociative or DID patients, dissociatively based hallucinations, delusions, and disorders of thinking are observed. Braun (1988) in his BASK model of dissociation, says patients utilize, to a lesser or greater extent, dissociation as a protective defense against unbearable behavior (self–mutilation), affect (rage, for example), bodily sensations (bodily “memories” of abuse, often psychosomatic symptoms), or knowledge (fugue states or amnesia). Interestingly, some researchers are now reporting the occurrence of trauma is a necessary, but not sufficient condition for the occurrence of PTSD. Rather, PTSD is thought to be related to impairment of the attachment–based cognitive functions that would allow trauma to be processed symbolically, or verbally (Verhaeghe & Vanheule, 2005).

Trauma Theory and the Reality of Abuse

There is an extremely high incidence of childhood abuse or trauma associated with the dissociative disorders. Empirical studies have established that 97 to 98% of cases diagnosed as DID or dissociative involve abuse (Putnam, 1989). Read, van Os, Morrison, and Ross (2005) reviewed 218 studies and concluded that “symptoms considered indicative of psychosis and schizophrenia, particularly hallucinations, are at least as strongly related to childhood abuse and neglect as many other mental health problems. Recent large–scale general population studies indicate the relationship is a causal one” (p. 330). The researchers claim until recently this causal relationship has been “minimized, ignored or denied” due to a “rigid adherence to a rather simplistic biological paradigm, inappropriate fear of being accused of family–blaming, avoidance of vicarious traumatization on the part of clinicians and researchers, and rediagnosing from psychosis to PTSD, dissociative disorders and other non–specific diagnoses once abuse is discovered” (p. 331). In a review of the Read et al. study, Oliver James (2005), in the United Kingdom newspaper The Guardian, wrote: “Not since the publication of R.D. Laing’s book Sanity, Madness and the Family, in 1964, has there been such a significant challenge to [the psychiatric establishment’s] contention that genes
are the main cause of schizophrenia and that drugs should be the automatic treatment of choice" (p. xx).

It should be noted that our contemporary research in attachment and epigenetics will provide clinicians with more scientific evidence for the folly of blaming anyone for psychosis or schizophrenia. In terms of blame, successful psychoanalytic and psychotherapeutic approaches recognize and avoid the untherapeutic nature of blaming either the patient or the family (Alanen, 1997; Karon & VandenBos, 1996). Searles (1979) was the first to point out specifically that pathological symbiotic attachment, or the hostile dependent relationship patterns found in schizophrenia and psychosis, contain both the seeds of rage and hatred, AND love.

**Psychoanalytic Interventions and Trauma**

Though Freud (1895/1955) started with theories that acknowledged the reality of abuse which accommodated the psychodynamic role of abuse in shaping the personality, he soon changed his focus to the role that unconscious fantasies had in shaping character. Freud never, of course, completely dismissed the role of actual trauma or the environment in shaping character. However, emphasis for several decades was on the role of the drives in shaping the ego. Classical analysis became progressively more focused on working with patients' verbal associations interpretatively. Abreaction, or the expression of emotion, due to either conscious or unconscious trauma, receded as a psychoanalytic technique. Exclusive use of verbal association and interpretation has been shown by research in the areas of PTSD, trauma, psychosis, and schizophrenia, to have limited, and sometimes contraindicated therapeutic benefit. Because such patients can have difficulty trusting another person sufficiently to establish a therapeutic alliance, techniques that reach to the patient's unconscious affective experience, such as utilization of the countertransference, abreaction, and the use of projective identification, are most helpful. Research in attachment, trauma, and neuroscience now confirms that psychotic patients constantly monitor interpersonal interactions, both consciously and unconsciously, for evidence of danger (Baker & Kim, 2004; Schore, 2003).

Trauma that is repressed, dissociated, or split off in psychotic, abused, and PTSD patients can be described as overwhelming affect associated with a *truth we feel we cannot face.* The truth of trauma cannot be faced, in my opinion, because the affective nature of being overwhelmed by the drives, or the bodily, sensation–based experience associated with
trauma, cannot be adequately modulated by utilizing techniques relying solely on verbal or symbolic functions. It has been my observation that the psychotic, schizophrenic, or traumatized person is consumed psychically and somatically with the reality of death, hatred, and evil (Gibbs, 2004, 2007).

Karon and VandenBos (1996) have provided detailed research that provides evidence that a modified psychoanalytic approach is effective when used with schizophrenics, though only when the therapists providing the treatment are highly trained in working with the population, and have an average of a minimum of ten years of such work. Karon and VandenBos (1996) emphasize a nonclassical psychoanalytic approach that recognizes the symbiotic attachment pattern already discussed, yet seeks to avoid the development of an unproductive maternal transference by utilizing both supportive and interpretative techniques. Not all analysts agree with Karon’s and Vandenbos’s modified approach, though analysts and psychotherapists working with psychotic patients have long realized the necessity of modifying techniques in some way (Jacobson, 1971; Silver, 1989). Transference work, as we will see when we review the Lacanian 388’s treatment of schizophrenia, is also typically modified.

The work done in the areas of attachment, trauma, abuse, dissociation, and PTSD has not gone unnoticed by clinicians across a range of disciplines and orientations. We will see the influence of this diverse research across disciplines and theoretical orientations when we review the contemporary successful treatments of psychosis and schizophrenia. Interestingly, the experience of immigration has also been identified as sharing many of the long–term behavioral features seen in PSTD (Jacobson, 1971; Krystal & Petty, 1963). Noting the similarity between reactions to extreme stress and psychotic behavior, clinicians have used these observations to develop treatment approaches to psychotic and schizophrenic individuals. Further, as long–term effects of extreme trauma, such as war and torture, are seen to be passed down from generation to generation (Davoine & Gaudilliere, 2004; Kane, 2005), in terms of familiar vulnerabilities to anxiety or depression, for example, the once biological model of genetic transmission of these psychological conditions began to develop into what is today called the Bio–Psycho–Social Model, or Epigenetics.

2. ETIOLOGY AND THE EPGENETIC MODEL: CONTEMPORARY NEUROSCIENCE AND EPGENETICS

Two questions immediately arise from the above overlap of treatment and behavioral similarities of the psychoses with the trauma, abuse, and
PTSD research. First, we are vexed by the question of differential diagnostic accuracy and etiology. I would like to ask a second question: in terms of the efficacy of the treatment—is treatment efficacy related to etiology?

Diagnostic accuracy does matter of course, in terms of identifying causal relationships, or etiology. Not all causal relationships, however, can be demonstrated by our methods utilizing observable, measurable, and replicable empirical methods. In terms of my question above—does the efficacy of the treatment matter in terms of the etiology of the condition, the answer is—yes, BUT, only within an epigenetic model. I will first briefly explain the area of epigenetics, before moving on to the research that is providing the basis for the successful psychotherapeutic and psychoanalytic treatments of the psychoses and schizophrenias.

In epigenetics, the relationships between biological, psychological, and social influences represents a matrix, wherein all of these factors are equally weighted, and organized as feedback loops (or epigenetic inheritance systems; Jablonka & Lamb, 2005) of fluid and complex influence within all human beings. For any particular condition, one of these feedback loops may be primary in terms of etiology, though the other two feedback loops can never be dismissed. Further, the total feedback system is fluid, and may affect any manifest biological, psychological, or social condition over time. Conditions we once thought to be heavily caused by biological or genetic factors, for example, after treatment focused in the psychological and social realms, may improve.

An example of the fluidity of the causal and treatment relationships in the epigenetic model are the studies documenting that the environment has an effect on the remediation of genetic deficiencies. Stephen Suomi (1997), Chief of the Laboratory of Comparative Etiology at the National Institute of Child Health and Human Development, of the National Institutes of Health, studied two groups of rhesus monkeys. The first subgroup manifested high anxiety and depressive–like symptoms from infancy, and high ACTH levels from infancy, which spiked whenever these monkeys were in new situations. The monkeys in the second group were hyper–aggressive, and made poor and impulsive social judgments. These monkeys had low 5–HIAA levels found throughout life. Genes have been identified that seem responsible for modulating 5–HIAA levels, which might support the choice of medication in an effort to modulate a neurophysiological condition. Suomi’s ongoing research, however, exemplifies how these conditions thought to be genetically determined, are influenced by psycho–social factors. Suomi’s group identified a group of “super–mom” monkeys who had nursed monkeys initially showing an anxious pattern, back to health. His group took monkeys from both the anxious–depressive and aggressive sub-
groups, and had them foster–mothered by these super–mom older females. All of these young rhesus monkeys, in both the subgroups, developed into troupe leaders. Silver (2003), in reviewing the research of Suomi and others, says: “Good home situations mitigate bad genes. Biology is not destiny; pathology is not immutable” (p. 327).

Research based on a Multi–Causal Epigenetic Model of the Schizophrenias and Psychoses

Etiology and Treatment. The issue of how the etiology of the schizophrenias and psychoses may, or may not be, related to the treatment of these conditions is important to clarify. As we have seen above, a comprehensive multicausal epigenetic model allows for multiple causal agents, and successful interventions that may or may not directly descend from the etiology of a condition. Thus, anxious and aggressive temperament may be largely caused by neurophysiological abnormalities, and be best remedied by environmental reparation and socialization (Suomi, 1997). Many contemporary psychoanalytic approaches to the schizophrenias are based on the disordered thought, language development, and speech associated with this condition. Psychoanalytic therapies, in spite of the evidence that a genetic vulnerability is operative in some cases of the schizophrenias, have found that techniques based on language development are successful in undoing the disorganized cognitive and language process, sometimes to the point of full recovery. Techniques such as the therapist avoiding the use personal pronouns, not asking questions, specifically wording interventions to help the patient develop the capacity to be self-reflective and use symbolic identification, and a modified understanding and interpretation of the transference, have been found by analysts from differing backgrounds to be among the most effective in the treatment of schizophrenic patients (Karon & Van den Blos, 1996; Renee, 1994; Segel, 1950; Ver Eecke, 2001; Villemoes, 2002).

The research of Denise Fort (1990) illuminates some of the language and communication deviances found in schizophrenic patients and their families, as well as illustrates the therapeutic benefits of verbal communication. Fort took normal sons and their parents, and schizophrenic sons and their parents, and studied proverb identification in these two groups. (The parents of the schizophrenic boys were not necessarily identified as schizophrenic.) The results found were:

parents performed less well after listening to a schizophrenic boy and sons
performed less well after listening to parents of a schizophrenic son. Fort concluded that there is a communication deviance in both directions. Schizophrenic sons were more impaired in their performance when responding to parents of schizophrenics than normal sons. Most striking, it was found that schizophrenic sons responding to parents of a normal son increased their performance on proverb identification to be equal to that of the normal sons.

Ver Eecke (2001) concludes that Fort’s research provides empirical evidence for refuting the claim that there is unidirectional impairment involved in schizophrenia, that is, that only parents’ communication deviance impairs children. Rather, there is reciprocal impairment of the parent and child. Fort recommends that this reciprocal impairment be noted in an effort to support families, and counter parental blame.

**Genetics—Analyzing the Adoption Studies**

There are many well done twin–adoption studies now available researching the etiology of the schizophrenias and psychoses. A few studies most relevant to the article’s thesis that the schizophrenias and psychoses are no longer seen as chronic deteriorating conditions, and that recovery is often observed with appropriate psychologically oriented intervention, will be briefly reviewed.

Tienari (1992) directed a Finnish adoption study finding that children of biological mothers with functional psychosis, given up for adoption, were more psychiatrically disturbed (10.3%) compared to children of control parents given up for adoption (1.1%). *The study also found, however, that no adopted child of a functionally psychotic biological mother acquired a functional psychosis if the adoptive family was deemed psychologically healthy.* The families were studied over two days (14 to 16 hours each), with each family receiving family, individual, and couple interviews (tape recorded for blind ratings, reliability, and reclassification by other researchers), the Consensus Rorschach, the Interpersonal Perception Method, and the MMPI. The OPAS, a 33-item family rating scale, was also done on the adoptive families. Using the 12 items with the highest reliability (between .0068 and 0.84), there were significant correlations between these independent ratings of the adoptive families and the individual diagnoses of the offspring (p. 164). The highest correlation was for empathy, disrupted communication, and conflict between parents and offspring (pp.164–66).

Tienari concludes that the findings are “consistent with the hypothe-
sis that healthy rearing families have possibly protected the vulnerable child” (p. 162–163). Portin and Alanen (1997) analyzed twin-adoption studies, environmental studies, and brain imaging research and concluded: “... it seems that the present day conclusion is that genes are neither sufficient nor a necessary cause of schizophrenia ...” (p. 3). Kendler and Diehl (1993) also conclude:

Schizophrenia is clearly a complex disorder in that gene carriers need not manifest the illness (incomplete penetration), affected individuals need not have the gene (environmental forms or phenocopies), diagnostic uncertainties cannot be avoided, and different families may carry different susceptibility genes (genetic heterogeneity). (p. 261)

Wahlberg et al. (1997) analyzed the interaction of high genetic risk (being the biological child of a schizophrenic mother) with the communication deviance of adoptive parents, as measured by the Index of Primitive Thought. Wahlberg’s results have significance in terms of etiology, treatment, and prevention of the schizophrenias. First, the increasing communication deviance scores of the adoptive parents were associated with sharp increases of positive scores on the Index of Primitive Thought for high risk adoptees (scores rise from 40% to 90%). This increase in communication deviance of adoptive parents, however, does not increase the positive scores for control adoptees. Secondly, it was found that when high risk adoptees were exposed to adoptive parents with low levels of communication deviance, these high risk adoptees have a lower proportion of positive scores that did the control adoptees (p. 361). Wahlberg’s research is related to Fort’s, both showing the protective role of the environment in ameliorating communication deviance. Teixeira (1997) also found that families with high communication deviance and negative affective style were most likely to have children who developed schizophrenia spectrum disorders. Ver Eecke (2001), in reviewing this research, concludes: “... It is as if the comparison adoptees develop more according to their own scheme whereas high genetic risk adoptees either drown or flourish depending on the environment ...” (p. 55).

Other Neuroscientific Research

After receiving psychotherapy, structural (sMRI) and functional changes (fMRI, PET) have been observed in persons with severe mental illness. Regarding this research, Brian Koehler, at New York University states: “We have within our grasp a potentially fruitful neural basis for
the psychotic structure, and its amelioration within psychotherapy . . . it is possible to study neural regions mediating empathy and intersubjectivity utilizing fMRI imagining” (Koehler, 2005). Ciompi (1980, 1984) also reports significant improvements in neurocognitive functioning, such as in memory, reasoning, and judgment, in schizophrenics receiving intensive psychotherapy; with up to 30% of diagnosed schizophrenics recovering.

The volume of the brain, seen through MRI imaging, is often reported to be reduced in people suffering from schizophrenia. Schröder, Bottmer, and Pantel (2002) have presented evidence that cortical volume changes are dynamic and reversible. Schröder et al. concluded: “The presently available neuroimaging studies do not convincingly support that schizophrenia is generally associated with a global cerebral tissue loss” (p. 93). Ventriculomegaly, one of the most prevalent neurological changes seen in schizophrenia, is nonspecific. In other words, these brain changes, many of which are reversible, are observed in schizophrenia, PTSD, bipolar and other depressions, as well as in the normal and aging brain. These neurological changes, then, nonspecific to schizophrenia and psychosis, are also responsive to functional and structural remediation through psychotherapeutic treatments (Schore, 2003). In related research, Waterland and Jirtle (2003) reported in Molecular and Cellular Biology that an enriched environment can override genetic mutations in mice.

Research in neuroscience is providing evidence that the therapeutic alliance in psychoanalytic treatments has a crucial, ameliorative role in repairing neurological and neural structural damage associated with insufficient attachment, psychotic symptomatology, and trauma (Aron and Anderson, 1998; Schore, 2003; van der Kolk, 1996). Havens and Ghaemi (2005) have shown that the therapeutic alliance, in appropriately conducted psychotherapy, functions as a mood stabilizer in patients diagnosed with bipolar disorder. Koehler is a major developer and advocate of the epigenetic model within psychoanalysis, and believes it will increasingly inform psychoanalytic and psychotherapeutic work. Koehler (2005) states:

The pharmaceutical companies are already researching how their psychopharmacological agents impact on the epigenetics of psychiatric illnesses. However, since the role of the social environment looms much larger within psychiatric epigenetics, psychosocial interventions, including most importantly psychotherapy, will be increasingly recognized as ameliorative.
The research of Eva Jablonka and Marion Lamb (2005) is related to Koehler’s emphasis of epigenetic models in psychotherapeutic treatments. Jablonka and Lamb have identified four pathways of influence in their Epigenetic Inheritance System: genetic, epigenetic, behavioral, and symbolic influence. Their behavioral and symbolic systems are relevant to social scientists trying to identify, and develop treatment for, all mental health disorders.

3. RESEARCH ON THE EFFICACY AND RELAPSE RATES ASSOCIATED WITH PSYCHOTROPIC USE

The last fifty years have slowly yielded many well-designed, controlled research studies that indicated, time and again, that long term use of neuroleptics worsens long term outcome, and greatly reduces the possibility of recovery from the psychoses and schizophrenias. Scooler, Goldberg, Boothe, and Cole (1967) looked at one-year outcomes for 299 patients in the first long-term study conducted by the NIMH. Patients were treated either with placebo or neuroleptics upon admission to a hospital. Those receiving placebo were less likely to be rehospitalized than those who received any of the three active phenothiazines: thioridazine (Mellaril), fluphenazine (Prolixin), and chlorpromazine (Thorazine). Epstein, Morgan, and Reynolds (1962) conducted the first large-scale study of hospital release rates in the 1950s for schizophrenic patients treated with and without neuroleptics, and concluded that “drug–treated patients tend to have longer periods of hospitalization” (p. 44). Prien, Cole, and Belkin (1968), in another NIMH study, identified what would later be called “re–bound psychosis,” or a increase of symptoms upon withdrawal from neuroleptics. They found that relapse rates rose in direct relation to dosage. Sixty–five patients were on 300 mg of chlorpromazine at the start of the study, and 54% of these patients worsened after drug withdrawal. One hundred thirteen patients were on more than 300 mg of chlorpromazine at the start of the study, 66% of whom worsened after drug withdrawal (p. 684). Prien, Levine, and Switalski (1971) in another NIMH study, confirmed the earlier finding that relapse rates rose in correlation with neuroleptic dosage.

Bockoven and Solomon (1975) compared relapse rates in the pre–medication era to those in the medication era, and found that patients in the pre–medication era had done better. Forty–five percent of the patients treated at Boston Psychiatric Hospital in 1947 (pre–medication era) had not relapsed in the five years following discharge, and 76% were successfully living in the community at the end of that follow–up period. These results are in sharp contrast with those of the medication era. Only 31% of patients treated with drugs in 1967 at a Boston commu-
nity health center remained relapse–free for the next five years. As a group these 1967 medication–era patients were much more “socially dependent” on public aid, such as welfare, than the 1947 cohort. Lehrman (1960) reported similar findings when reviewing relapse rates for patients in New York psychiatric hospitals. Lehrman (1982) found that individual psychotherapy, without an overreliance on neuroleptics, was the most helpful approach to assist chronic schizophrenics in returning to the community, and, in some cases, recovering from schizophrenia.

Rappaport, Hopkins, Hall, Beleza, and Silverman (1978), in a study interestingly entitled “Are there schizophrenics for whom drugs may be unnecessary or contraindicated?” randomly assigned eighty young male schizophrenics admitted to Agnews State Hospital to medication and nonmedication groups. Only 27% of the drug–free patients relapsed in the three years following discharge, compared to 62% of the medicated group. In a large multiple–study research project conducted under the auspices of the World Health Organization, the WHO demonstrated that in underdeveloped countries where use of neuroleptics was at a minimal rate, or nonexistent, persons diagnosed with schizophrenia had better outcomes (Harrison et al., 2001; Hopper et al., 2007; Jablensky et al., 1992). Whitaker (2002), in Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill, discusses the findings of the WHO at length, and concludes that maintaining people on neuroleptics is a disservice, it worsens long–term outcomes, and makes recovery more difficult. He also answers the charge of contemporary researchers that the newer atypicals and other psychotropic medications are more effective than early medications. Whitaker states that research now indicates that these newer medications are often no more effective than placebo, are not improvements over older psychotropics in terms of efficacy, and are more often associated with serious side effects. He confirms the findings of the WHO study: outcome and recovery rates for the psychoses and schizophrenias are better in undeveloped countries that do not use, or use minimally, neuroleptics, and focus on psychotherapy, family therapy, psychosocial education and community support.

4. THE HUMAN RIGHTS AND PSYCHIATRIC RIGHTS MOVEMENTS

Emerging from the research showing long–term use of neuroleptics worsens longterm outcome, and minimizes the possibility of recovery, is the Psychiatric Rights movement. This movement has its basis in the Human Rights movement. The basic tenets of the Psychiatric Rights movement are the primacy of individual choice when the individual is not a
threat to self or others, informed consent, the right to privacy, and the professional ethic to do no harm. Grace Jackson (2005), a psychiatrist and researcher, provides an exhaustive examination of the short and long-term side effects, and the efficacy of psychotropic treatments. Jackson also provides documentation of the massive influence pharmaceutical industries have had on outcome research and medical school curriculums and how this industry has increasingly monopolized standards of care in the healthcare and legal systems, based on profit motives instead of scientific research. Jackson’s Informed Consent: Rethinking Psychiatric Drugs, is one of many works that now calls for a careful examination of the use of all psychotropic medication in the United States (Glenmullen, 2001; Healy, 2004; Jackson, 2005; Whitaker, 2004). Jackson and others seem to be making the point that there is now sufficient research available to alert us to taking a cautious approach to medication use.

**Psychoanalytic Contributions to Recovery from the Psychoses and Schizophrenias—Contemporary Successful Treatments**

Because of the unconscious repetition of trauma in both individuals and families, as well as particular attachment and object relations patterns that contribute to compromised language development and intrapsychic psychotic structures, I believe it is only a psychoanalytic approach that can truly free a person having a “psychotic core” from a downward cycle into terror, alienation, and psychotic deterioration. The Lacanian “388” program will be reviewed in some detail, as its overall treatment approach integrates much of the psychoanalytic, language development, attachment, and epigenetic research already covered. Other effective treatments will also be briefly mentioned.

**Quebec’s 388**

The Treatment Program for Psychotic Young Adults, commonly referred to by its street number in Quebec, 388, was founded by Drs. Willy Apollon, Danielle Bergeron, and Lucie Cantin. They all obtained psychoanalytic training, under the auspices of Jacques Lacan. Work done previously by both Freud and Lacan had not been promising in developing a therapeutic transference with psychotic patients. While Freud (1915) hoped that the study of the ego would provide the means to eventually treat psychosis, he could find no means to facilitate a therapeutic
transference with such patients. Lacan (1993), in his treatment of a paranoid woman, also came to the conclusion that the psychotic could form a transference, but that it would inevitably become persecutory, or would produce an erotomania, resulting in unsuccessful treatments.

Not to be deterred, Apollon, Bergeron, and Cantin drew upon their Lacanian training and went on to develop the analytic concepts and techniques necessary to establish a successful transference with the psychotic person. Briefly, these concepts are based on an understanding that a particular defect in language, that affected the psychotic’s relations to symbolic order, interfered with accessing necessary cognitive functions within psychic structure. When a person experiences a psychotic “crisis,” the experience is one of being subjectively inside the destruction of the world. The representational field that forms the template for object relations is shattered. This shattering crisis leads to what is termed a “ruptured social link” (Apollon, Bergeron, & Cantin, 2002).

The similarities of the observations made by Apollon, Bergeron, and Cantin with those that have already been presented, in terms of attachment and psychic structure, language development, and the subjective experience of terror associated with death and destruction, are apparent. These observations are all reported across various disciplines and orientations that work with psychotic and schizophrenic patients.

When a crisis inevitably arises, then, the analytic process is supported by the structure of 388 and viewed as a therapeutic opportunity. The minimum requirement to enter 388 is for the patient to make a request. This first manifestation of patient–as–agent is then sustained, first during the initial interview, and then throughout the patient’s contact with 388. Each patient is worked with to identify a unique “project,” or a personally meaningful activity that helps to rebuild the patient’s shattered social link. Patients are expected to enter psychoanalytic treatment, and this is kept entirely separate from the program at 388. The patient’s analyst, importantly, has nothing to do with what goes on in the program at 388.

There is no formal group therapy at 388, instead group process serves the function of containing delusional efflorescence and offering ways to rebuild the ruptured social link. Artistic studios occupy a special place at 388. They provide a unique and protected space where each patient can locate their own desire. This is done by employing various media in order to capture and contain the otherwise inexpressible and ineffable experience of one’s psychosis and unique history. Lacan’s work on desire informs a complex theory of the structures that underlie the psychotic person’s delusions and hallucinations. For our purposes, suffice it to say that the treatment at 388 is organized around providing a “localization
for desire,” in the sense that it reorganizes psychotic structures underlying delusions and hallucinations, using Lacanian analysis.

The four rooms of the third floor house seven beds, and are available on a 24 hour/seven day a week basis. Any person involved in the 388 program who is in “crisis” can voluntarily go to the third floor, and have an “intervenant” (388 staff) available, as much as is needed. Finding a way to accept the ineffability of some things, especially of the psychotic experience, is a central part of the work done at 388. Patients are called Usager because they “make use of” the Intervenant to accompany them through the psychotic experience. This accompaniment is similar to Prouty’s (2003) pre-therapy with schizophrenic patients, in which the therapist may make very few verbal comments, ask no questions, and simply be available. The usager agrees to involve himself or herself in analytic treatment and is always free to come and go, leave 388, go to the third floor for round the clock care when needed, stay at home, or go to school. In this way the 388 program treats psychosis where it is most advantageous to do so, right in the community.

Charles Turk (2006), a psychiatrist in Chicago working with psychotic patients for over 30 years, says:

In the United States after the second hospitalization a schizophrenic patient is usually considered to have become chronically ill. The average number of hospitalizations prior to entering 388 is about 4.5 per patient. The experience of having the availability of an intervenant, combined with their analysis, in some cases results in complete recovery from schizophrenia, eliminating the need for medication . . . the experience here is that people’s lives are turned around.

Reverse Psychiatry in Falun, Sweden, and the Turku Schizophrenia Project in Finland

Lars Martensson (2004) is a Swedish psychiatrist who recently spoke in San Diego on the recovery from schizophrenia. Martensson spoke primarily of a program in Falun, Sweden, under the direction of psychiatrist Goran Andre.

Goran outlines the four cornerstones of the Falun method as:

1. Psychosis is seen as a crisis, a crisis to be overcome.
2. A session with the whole family is arranged within 24 hours.
3. Neuroleptic drugs are avoided and hardly ever used.
4. Hospitalization is avoided and hardly ever necessary.
The Falun method is based on relational theories of establishing an empathic mutual relationship with another person, and neuroscientific and attachment research already covered. It is also grounded in the neuroscience of human consciousness, with Martensson explaining that this process is similar to establishing this mutual relationship as with a baby. Martensson says:

Let us compare the relation between the doctor and the patient with the relation between the mother and the baby at the moment the baby is mentally born by the leap to an outside viewpoint. The leap, we understand, is only possible because of the empathy, dedication, openness, total presence of the mother. There are no ulterior thoughts, no manipulation. This is Love. Human consciousness is born of Love. The task of the psychotic person, as we noted, is similar to the task with the baby. The task is to activate the frontal brain function that underlies all human consciousness. (p. 6)

Lars Martensson states: “It is an unbearable horrible tragedy when a young person, often a gifted, sensitive, creative young person, is drowning in psychosis . . . They can be saved. Therefore they must be saved” (p. 6)

The Turku Schizophrenia Project in Finland

The Falun treatment approach is similar to that developed by Yrjo Alanen and his team of researchers at the University of Turku, Finland. Alanen’s approach to the treatment of schizophrenia now has four decades of outcome research strongly pointing to the efficacy of the “need–adapted approach” (Aaltonen, Alanen, Keinänen, & Räkköläinen, 2002; Alanen, 1997; Alanen, 1991). A psychotherapeutic attitude dominates all aspects of treatment, including psychopharmacological regimes, family therapy, individual psychoanalytic therapy, and institutional and interdisciplinary countertransference resolution. Such processing of institutional group dynamics, as well as individual countertransference responses, is central to effective treatments of the psychoses and schizophrenias. Hinselwood (2004) in his book *Suffering Insanity* has written specifically on the conflicts seen in institutions, and between disciplines, in the psychoanalytic treatment of psychosis. The Turku Schizophrenia Project also provides advanced training in treating psychotic patients for psychotherapists and psychoanalysts throughout Scandinavia and Europe. Case studies of work with psychotic patients
through the Turku project can be found in Jackson’s (2001) *Weathering the Storms: Psychotherapy for Psychosis*.

**SUMMARY AND CONCLUSIONS**

The contemporary research in the areas of attachment, object relations capacity, affect regulation, language and cognitive development, and trauma were reviewed. The functional capacities observed by early psychoanalysts, such as affect regulation, mature object relations capacity, and primitive defenses, have been documented by contemporary findings in the areas of neuroscience and epigenetics. Clinical observations have noted similarities in the behavioral manifestations of psychotic, schizophrenic, and traumatized patients. Effective psychoanalytic and psychotherapeutic treatments for the psychoses and schizophrenias have been developed by synthesizing the findings across the above disciplines. Outcome data has substantiated the effectiveness of psychoanalytically informed treatments of the psychoses and schizophrenias. I posit that two other factors have laid the groundwork for the emergence of effective psychotherapeutic and psychoanalytic treatments of these patients: poor long–term outcome and recovery rates for medication-only treatment of the psychoses and schizophrenias, and the emergence of the Psychiatric Rights Movement.

The Lacanian 388 Program was examined in some detail. Other effective treatments for the psychoses and schizophrenias were also briefly reviewed. All programs reviewed focused on psychotherapeutic interventions as primary, and used medications minimally, not at all, or only as informed by an overarching psychoanalytic or psychotherapeutic model of treatment. All these treatments aimed to be available to the families and the communities of the patients, and were flexible in making any modifications necessary in terms of technique and transference work. In all treatment approaches recovery from schizophrenia was assumed to be possible, and probable in many patients. The individual and group treatments reviewed are based on clinical work now spanning over seven decades, and on contemporary research in trauma, neuroscience, and epigenetics.

Madness is frightening, and cannot be observed from a so–called “objective” professional stance. The madness of our patients will inevitably affect us deeply in terms of countertransference responses because the madness of the external Other resonates with our own internal madness. The terror and chaos that is involved in these treatments is difficult to bear. Countertransference reactions can and should be ultimately used to further the therapy or analysis (Bollas, 1999; Gibbs, 2004, 2007). A willingness to be flexible in terms of accommodating technique to the needs
of the psychotic patient, without compromising the gains possible from always working as analytically as possible, is required. The successful individual practitioners and larger treatment programs reviewed herein all utilizes some mechanism for ongoing training, the effective utilization of the countertransference, and the processing of dynamics amongst team members. In conclusion, based upon this research and clinical work: The psychoses and schizophrenias can no longer be seen as chronic deteriorating conditions; recovery is observed in many patients treated with approaches that focus on the primacy of psychoanalytically–oriented psychotherapeutic intervention.

REFERENCES


Schore, A. N. (2001). Effects of a secure attachment relationship on right brain develop-
ment, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*, 7–66.


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