A Primer for Psychotherapists

Kenneth Mark Colby M.D.

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SCHIZOPHRENIAS

Everything that we have said thus far about psychotherapy is subject to modification in the schizophrenias. By “schizophrenias” (admittedly a semantic monstrosity) I mean that group of psychological conditions characterized by the patient’s inability, of varying degree, to distinguish psychic thought from material reality. Material reality consists of perceptions which can be made to appear and disappear through motor activity. Everyone—normal, neurotic, and psychotic—has at times some degree of difficulty in differentiating what perceptions are realistic and what perceptions originate from mental processes. In normal and neurotic ego states the person can recognize unrealities spontaneously or when they are pointed out to him. Psychotic ego states hinder the function of this differential in proportion to their mild, moderate, or severe extent.

In Chapter 1, it was stated that neurotic symptoms result from conflicts between wish-impulses and defenses. By abolishing, modifying, or increasing the defense of wish- defense conflicts, symptoms can be removed or attenuated. The technical devices utilized in an uncovering therapy are designed to decrease the defenses of a neurotic ego which for the most part can correctly assess reality. For example, when it is demonstrated to him, the neurotic patient can understand and be convinced that his transference feelings are unrealistic, not being based on realistic knowledge of the therapist but arising from an image in his mind determined by his past.

But in the schizophrenias an already shattered ego defense structure, unable in large degree to judge reality and hence to cope with it adequately, is trying to reconstitute itself by adding and strengthening defenses. A psychotic ego attempts to heal itself by becoming neurotic. Thus psychotherapy in the schizophrenias is mainly covering, i.e., defense-adding, rather than uncovering, in order to aid spontaneous healing processes. The aim of such therapy is to convert a psychotic ego state into a normal or neurotic one and enhance its reality-testing.

The modifications of therapy to be suggested apply to schizophrenias often called “ambulatory” or “latent.” They pertain to non-hospitalized patients who come voluntarily for help an hour or two a week, who thus have a sufficient residue of reality sense to realize that they are ill and who can form a friendly attachment to a therapist whose statements they deem deserving of attention. The management of each

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case is directly dependent on the state of this attachment and on the patient's degree of reality-testing.

Before entering a discussion of techniques, let us first consider what I feel to be the chief error made in the psychotherapy of schizophrenias. It is that the therapist does not recognize he is dealing with a schizophrenia at all. The patient is mistakenly viewed and treated as a neurotic. Such an error results from an inaccurate or incomplete concept of schizophrenic symptomatology. Textbook descriptions emphasizing delusions, hallucinations, ideas of reference, and so forth are misleading, since they portray advanced psychotic conditions and overlook the milder forms. Hence the following section on diagnosis of schizophrenias is included to acquaint the beginning therapist with common clinical pictures made up of the more subtle and less conspicuous signs and symptoms of this type of ego-state.

Diagnosis

No single sign or symptom determines a diagnosis of schizophrenia. A neurotic patient may have one or two of any of the following traits. It is when several of them combine to form a constellation of related symptoms that a schizophrenic process is diagnosable.

In the beginning interviews, the psychotic patient may appear extremely anxious, glancing about the room with a startled or suspicious look. His eyes may dart from side to side or the eyelids widen momentarily to reveal unusually large areas of the white sclerae. Though looking intently at the therapist with the first handshake (often presenting a flaccid, cold, but sweating hand), he may from then on constantly avert his eyes from the therapist's gaze. He rigidly holds his body in one position for a long time. Sometimes he has a small characteristic gesture which, until one is used to it, does not harmonize with what is being spoken. Before an interview has ended, he may suddenly arise to leave.

The verbal behavior may have several typical qualities. Many polysyllabic words are used in a stilted, somewhat pedantic manner, as if the word itself were more important than the facts it describes. The patient speaks in vague and spreading generalities, so that even after he has described at length what troubles him, one is not quite sure exactly or specifically what does. In the description it often sounds as if he were a distant spectator of himself or a reporter of another person. The content of his speech is unusual. Neurotic patients—except psychologically lettered intellectuals who have decided

from their reading what should be brought out in therapy—do not immediately or easily speak of sexual, incestuous, homicidal, or certain bodily topics. It is only after the usual resistances against expressing such ideas have been gradually removed in therapy that they are verbalized. But in schizophrenia the patient may in the first interview blandly speak of desires to have intercourse with his mother, impulses to cat another's feces, or wishes to exhibit his genitals. In other words, there are too few resistances against discussing instinctual impulses rather than too many. Thus if the patient were allowed to free-associate, it would be observed that he associates literally too freely, producing a chaotic mass of disconnected thoughts lacking in the ordinary conversational restraints of propriety. On the other hand he may show great reluctance and discomfort in telling something which when revealed seems (to the therapist, but obviously not to the patient) unwarranting of that much turmoil. For example a slim and attractive girl struggled for weeks to tell her therapist the secret though real cause of all her difficulties—namely, that she was fat.

Common symptoms complained of are fatigue, disinterest, and lack of concentration. The patient may experience diffuse and fluctuating sensations of unreality. He feels estranged from the world around him, and internally he feels as if something has fallen away, leaving him hollow inside. Such a depersonalization is often accompanied by a hypochondriacal preoccupation with body surfaces, orifices, and organs. Periods of being unable to feel strongly about anything are punctuated by outbursts of intense emotions, particularly of rage. Any of the neurotic symptoms may develop in a mild to severe form. In fact if a patient shows several symptoms typical of different neuroses, e.g., phobias, compulsions, and conversions, one should look for further evidence of a schizophrenia. Severe depressions in young people and severe hysterias at any age are significant indications worth keeping in mind.

The patient's daily thought and behavior contain certain elements of diagnostic significance. Long, involved, and dramatic day-dreams may occupy much of his attention. They are full of murders, grandiose accomplishments, widespread destruction, and sexual orgies. Sexual thoughts concern polymorphous perverse activities—exhibitionism, incest, sado-masochism. In his sexual life he prefers masturbation, engaging in it several times a day, often without any accompanying fantasies. Or he may have extremely frequent intercourse, during which he may be anesthetic and have no fantasies or the latter may be of a sado-masochistic nature. Perversions such as transvestitism, fetishism, or exhibitionism are often the living-out of a psychotic ego state.

Patients with schizophrenias become successively fascinated with all sorts of esoteric cults, fads, and mystical systems of thought. They show an eager curiosity about complex religious and philosophic questions. Psychological theories, electronic machines, and currently publicized sciences such as cybernetics or semantics are favorite subjects. As one interest fades, another takes its place. The patient may subject himself to various rituals or procedures demanded by the cult, for example, dieting, practicing eye- movements, or prolonged meditation. Although he allies himself with groups in this fashion, he seldom feels close to anyone in the group. Isolated from other isolated people, he soon begins to feel they do not like him or they are against him and he leaves, later to find another group and repeat the whole cycle again.

The past history of the patient offers further diagnostic material. One or both parents may have been psychotic. If she is not psychotic, the mother is often a highly narcissistic person who cannot "give" to her children, especially during their first year of life. The patient's childhood experiences include frequent severe anxieties, panics, or even true delusions. It may be discovered that he has always been greatly upset by environmental changes such as a new school or a new house. A history of alcoholism in adolescence or a prolonged period of bed rest at this time without evidence of a serious physical disease often indicates transient psychotic episodes. Attempts (sometimes successful) to have the nose, lips, or forehead changed by plastic surgery are frequently observed in schizophrenias. A long history of a severe "psychosomatic" disease such as eczema or colitis should induce the therapist to look for further signs and symptoms as outlined above.

Finally in the therapeutic interviews a few phenomena may herald a psychotic ego state. The sudden improvement or disappearance of a long-standing neurotic symptom after only a few hours of therapy often occurs in schizophrenias. The patient may show extreme sensitivity to the therapist's statements or facial expressions. He dreams profusely and is often extremely disturbed by the bizarre nature of the dreams. They involve scenes of mass destruction, weird animal or insect-like shapes, and bodily distortions and mutilations.

A patient showing several of the mechanisms we have described should make the therapist think of schizophrenia. To make this diagnosis is more than an academic question, because psychotherapy in a schizophrenia differs widely from psychotherapy in a neurosis. The ways in which it differs will now be

discussed from the standpoint of the topics considered in the book thus far.

Time and Space Conditions

Beginning and ending the interview can be leniently arranged. A resistance of late-coming need not be discussed. If the patient strongly feels at any time during the hour that he wants to leave, he should be allowed this freedom. The therapist should not terminate the interview if the patient appears confused or uncertain about some point discussed. Often it is helpful to make a brief summary of the interview's main points at the end of each hour.

A patient enveloped in magical thinking may look on many of the objects in the therapist's office as having some hidden significance. This is particularly true in the case of a couch. Most therapists feel that patients with difficulty in reality-testing should not be placed on a couch, since it adds to the "unreal" quality of therapy.

Interview Behavior

The patient is extremely alert to everything the therapist says or does. The therapist's gestures, changes in position, and facial expressions may be perceived as having double, personal, or magical meanings for him. Slight indications of exasperation or hostility are watched for, and when discovered they are felt as major rejections. Hence in his actions and attitudes the therapist should lean toward a more friendly, benevolent, accepting, and giving role than is required in treating neuroses. One accepts gifts with thanks, carefully observes the claims of etiquette, takes the patient's side in family conflicts—all in an attempt to gain and preserve friendly transferences. H. Sullivan's deft advice is that the therapist should try to avoid collisions with the patient's self-esteem. This attitude can be carried out within the bounds of a professional relationship. Moving too close interpersonally to a patient can frighten or antagonize him just as much as remaining too distant.

Relatives can be interviewed only with the patient's permission. He should be allowed to sit in on the interview, especially if he may be suspicious that the therapist is really an ally of parents or relatives trying to force him to live according to their rules and desires. If he is not present, he should be told later what was said. No guile or lies, however white, are permissible.

In working with out-patients once or twice a week, the therapist must be prepared to deal with telephone calls between interviews. They may be of great significance in the patient's repeated testing to see if there really is a reliable person taking an interest in him.

The First Interviews

With neuroses the technique of the early interviews involves alternate silences and interpositions, usually questions. But with psychoses there is a quantitative change in that the therapist makes less use of silence. Silence becomes dreadedly loud in these patients' ears, and it is interpreted by them as a reticence due to disinterest or dislike. When the patient stops talking and appears to be struggling with the silence, one helps him to start up again with a question or some other interposition. Also in this regard, the therapist never meets a question from the patient with silence but makes some response to it. Thus, in general, the therapist is more active and directive in questioning, focusing, explaining, i.e., interposing.

Questions should be asked with a minimum spirit of quizzing or probing. Nor should they carry an air of being heavily weighted with significance. Attempts to pry into his deeper thoughts and fantasies too soon invariably lead the patient to recoil all the more from an at best tenuous relationship. As P. Federn has stated, the therapist should not try to uncover the details of previous psychotic episodes. Any areas of the patient's life for which he has an amnesia should not be tampered with. Such spontaneous resolutions of conflicts through strong repressions are defenses best left intact.

During the beginning stages of therapy and long into the middle course of the treatment, the therapist must agree with the patient's ideas, however unrealistic they are. This does not mean that a delusion is actually confirmed, but neither is it directly opposed by the therapist. This technique is illustrated in the following example:

Convinced that his next-door neighbors don't like him and do various things to inconvenience him, a seclusive man has fits of rage. His family tells him his ideas are all nonsense, but of course it only adds to his rage that they should ally themselves with the neighbors.

In the first interview he asks the therapist for an opinion about his ideas.

Pt.: Do you think it's my imagination, that I'm crazy as they say?

Ther.: From what you've told me, it's hard to tell what is going on there with your neighbors. It can't be all your imagination. Maybe it's a mixture of things, a little of both.

Pt.: Yes, that makes sense. But I can't understand what they would have against me.

The important point here is not that the therapist's statement intends to shake the patient's belief but that the therapist does not act like others in trying to argue him out of it. Instead he allows room for the patient's belief to have some justification. Repeated experiences of this kind with his therapist will eventually make it possible for the patient to be influenced by one who understands him and respects his views.

In contrast to the technique suitable for neuroses, the therapist does not in early interviews attempt vigorously to elucidate a major area of conflict. Rather, in learning about the patient, he tries to evaluate in which areas the patient's ego functions adequately (i.e., normally or neurotically) and in what areas the ego has difficulty in reality perception and testing. Once the latter becomes clear, therapy can be directed toward nursing a seedling of reasonable ego to extend into some of those areas. The major life area to be clarified and understood for its realistic-unrealistic components is the patient's relationship to people. His withdrawal and isolation based on fears or resentments are defenses eventually suitable for interpretive modification. All natural restitutive symptoms such as hallucinations, world-reconstruction fantasies, and encapsulated, systematized projections should be respected for their healing functions and left unprobed.

When the patient urgently expresses his fears of insanity, homicide, or suicide, they should be frankly discussed. The therapist's own apprehensive reluctance to enter these topics may serve to frighten the patient further. Such fears are not entirely baseless in schizophrenias and must be treated with a calm thoroughness which attempts to stress the wide separation between thought and act.

One type of interposition common in the beginning, as well as at other stages of the therapy, consists of advice. At times the therapist must offer practical suggestions to the patient whose reality judgment is so impaired as to jeopardize his best interests. For example, a patient whose concept of his body is distorted may be advised not to undergo the plastic surgery he has planned. Or it may be suggested that a patient change his living quarters where he is under the constant unnerving pressure of

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homosexual feelings toward a room-mate. As with all advice-giving on the part of the therapist, it should be done cautiously and in small doses. The therapist must be prepared for the prospect that often his advice will not be taken or, even worse, that it will be followed but have bad results.

The Middle Period

It is typical of one with a psychotic ego state that he has no difficulty in being or becoming aware of his basic instinctual wish-impulses. However, this “tragic miracle of consciousness” handicaps rather than aids him. His preoccupation with a welter of erupting impulses serves to estrange him further from a real world of people and events. Hence in interpretation the therapist in general does not confront the patient with warded-off impulses but with the way in which the patient is concerned with these impulses in order to ward off reality. The therapist in interpreting disregards the actual content of day-dreams, fantasies, and ruminations and centers his discussion around their use as a defense against reality, as in the following example:

When trying to complete routine homework requiring continued concentration but no original inventiveness, a mathematics student would drift off into reverie at his desk. He describes seeing himself on a platform in the stadium before thousands of people. He and a beautiful girl perform an orgy of intercourse followed by eating and smearing one another with feces. The patient wishes to enter a discussion of the content of this fantasy.

Pt.: When I thought about the day-dream it seemed to prove my anal impulses. Do you think my trouble is that I’m really an anal-erotic?

Ther.: Oh, I don’t know if that’s so important. I’m more interested in the fact that you get this day-dream when you are working. Perhaps when the homework bores you, you try to escape it by day-dreaming.

Pt.: Those problems he gives us every night are a waste of time. A child could do them. And what gets me is that so much of my grade is based on them.

Ther.: That’s why this is an important point. The only good reason for doing the problems is to pass the course. They probably are an insult to your intelligence, and you avoid them out of resentment toward your professor. But if, as you say, you are really interested in a degree you will inevitably have to do things you don’t like.

Rather than become involved in the instinctual material, the therapist deals with the patient’s interpersonal basis of avoidance of realities important for his long-range life goal.

The therapist’s interpositions and interpretations should repeatedly emphasize the patient’s present life situation and how he is meeting it. The problems of day-to-day living are gone over, often paying attention to the smallest details, e.g.:

As has been her custom, a young woman begins the hour with an exposition of her idea that all the members of her family are against her. She repeats the grievances that the therapist has heard numberless times before. Instead of allowing her to go on into the complex ramifications of her idea, the therapist by his questions focuses the patient’s attention on her reality life.

Ther.: Now could you tell me what you have been doing this week?

Pt.: Tuesday I went shopping. I was looking for a certain kind of brooch to replace one I had lost or maybe it was stolen. I wouldn’t put it past my sister to do something like that.

Drifting into her suspicions again.

Ther. (*interrupting*): And after the shopping?

Pt.: I met a friend for lunch. She’s the girl I told you about last time. We had lunch at the hotel. I began to feel uncomfortable there.

Ther.: What was upsetting you?

Pt.: Others looking at me, I guess. Worried about my appearance.

She now goes to the topic of her social anxiety, a subject that is usually fruitful for investigation and interpretation.

Once the patient begins to trust the therapist and form a friendly attachment to him (this may take a long time), he can be influenced little by little to accept alternate realistic explanations of events which trouble him. The types of transferences developed by the patient are exactly like those described for neuroses. Contrary to former opinions, they may be just as intense, though less apparent, than transferences made by other patients. In fact those transferences ascribing a magical parental omnipotence to the therapist are often accentuated.

Aiding the patient’s reality-testing means to offer views different from his, relying on the transference attachment to win his giving them serious thought. The therapist’s alternate views are

formed with the aid of his own reality sense, some of which he then attempts to put at the disposal of the patient, as in the following procedure:

A sensitive and distrustful office worker is certain that many of the activities in his office have reference to him. The therapist has never contradicted these thoughts, letting them pass by. At this point in therapy, however, he feels that the patient might listen to another explanation without feeling so injured as to withdraw his friendliness for the therapist.

The patient has just mentioned that a colleague closed a window in the office, intending to stifle him.

Ther.: What gave you the feeling he did it to inconvenience you?

Pt.: Because I had opened it a few hours before, so he knew I wanted it open.

Ther.: Do you think he remembered it was you who opened it?

Pt.: I don't know. There are so many people in that office. Why?

Ther.: I know how you feel about your fellow-workers there, but in this case of the window I was thinking there might be another explanation for it. Namely that he closed the window without thinking about you at all. I could imagine that he didn't know who opened it, that he closed it only for his own comfort, and that he had no intention of bothering anybody.

Pt.: Could be. But it does bother me to have the window closed.

Ther.: Sure it does. Because you feel bothered, maybe that's why you think someone is trying to bother you. But you can see that if something results within you, it doesn't necessarily follow that that was its original purpose.

The therapist tries to teach the patient to distinguish between a purely inner experience and an outer event.

Thus in learning to test reality the patient with the help of the therapist goes over dozens and hundreds of daily experiences seeking to recognize the difference between what actually occurs in the external world and what he interprets as occurring according to distortions produced by his own inner ideas. Out of this process an identification develops with the therapist's normal adult ego state and the patient slowly gains reality sense and begins to layer over remaining unrealistic concepts with more conventional attitudes, i.e., to "make like normal."

Since many patients tend spontaneously to intellectualize, the therapist may try to capitalize on this resistance through offering psychological information and explanations. By fostering the patient's intellectualized defenses, an increase in base-line resistances is therapeutically induced to provide reinforcement for a friable ego. For example:

So great was his anxiety around people whom he did not know that a librarian could not enter a restaurant alone. Also if someone looked at him on the street, he felt uneasy and wanted to get away. Knowing from other evidence that the patient felt very guilty about his secret sexual fantasies, the therapist had one day casually stated to him that the reason he felt anxious around people was his unnecessary fear that they could read his sexual thoughts. During subsequent weeks the patient lost a large part of his social anxiety and could move freely among strange people.

How the interpretation, perhaps relevant but somewhat too glib and inexact, was put to use by the patient is shown in this interview months later. In passing the patient mentions his old anxiety.

> **Ther.**: Looking back, what do you think it was you were afraid of around people?
>
> **Pt.** (*immediately unsettled*): But didn't you say it was because I feared they could tell about my sexual thoughts?
>
> **Ther.**: That's right.
>
> **Pt.** (*relieved*): Well, then I said to myself, "How could they know what I thought?" And knowing they can't, there's nothing to be afraid of.

The therapist sees that his previous interpretation was accepted by the patient as *the reason* for his anxiety. Ascribing his anxiety to the explanation given by an authority who "knows things," he is able to reassure himself there is no need to be afraid because he has sufficient reality-sense to know that people cannot tell what he is thinking.

Not all of the therapeutic work is intended to help a psychotic ego to mend fences through adding defenses. Certain symptoms can be treated by attempts to lessen the defenses involved. Social anxiety based on a projected fear of punishment, withdrawal, and some types of guilt feeling are common problems in which the superego burden may be ameliorated. Also each patient may have some particular conflict which the therapist judges can best be handled by an uncovering interpretation rather than by a covering interposition, as in this example:

The thirty-year-old virgin daughter of a clergyman enjoyed smoking the few times she tried it. However, after each intemperance she felt she had sinned and became depressed. During therapy the patient had begun to smoke an occasional cigarette, partially out of identification with the therapist. In this hour she describes her guilt and its relation to violating her father's command, then asks:

Pt.: What do you think about my smoking?

Ther.: I don't think smoking is such a sin. Part of you thinks so because your father says so, but I feel your father is overly stem in this respect. Smoking is a small pleasure that you should feel free to enjoy.

The patient seeks permission for an instinctual pleasure from a substitute father. He gives it hoping to diminish a reaction formation and allow fuller impulse gratification.

It cannot be overstressed that a friendly transference is the fulcrum for effective psychotherapy with these patients. Once the patient becomes persistently antagonistic or involves the therapist in persecutory delusions, therapy should be discontinued without attempting to work it out. Often a trial with another therapist, allowing the first to be the needed recipient of displaced hatred, will prove more successful. Transference resistances, which may supplement defenses against a psychotic engulfment, should be permitted to function for a long time, perhaps forever, without interpretation.

A few conflicts may be worked through in the way described for neuroses in the preceding chapter. But the bulk of therapeutic work consists of repeated efforts to help the patient discriminate between his wishes and fears and external reality. Concentrating on his manner of relating to people rather than his interest in words and abstract ideas, therapy can convert the patient's psychotic level of adaptation to a normal-neurotic one with relief of his distressing symptoms.

Ending Therapy

The same principles for ending apply here as were outlined for neuroses. If at any time the patient wishes to interrupt therapy, he should be allowed to do so, even in the face of objections from relatives or friends. Those patients who wish to continue, though further therapeutic work seems hopeless, should not be completely denied the opportunity to talk over their problems with a therapist. They can be seen at infrequent intervals and, as happens in a clinic, by a succession of therapists. Often through interviews

held only once a month or even once or twice a year, a patient can function within the equilibrium of a compensated neurotic- psychotic ego state for life.

An Illustrative Series of Interviews

To illustrate some of the technical modifications discussed, several interviews from the middle of therapy in a clinical case are presented.

The patient is an intelligent young woman in her early twenties. She comes to therapy complaining of anxiety attacks, depression, and confusion about her position in life. At present she stays at home with her parents, going out only to shop. Until a year ago she attended college, but she found the work too hard. She describes her father as a friendly, jovial man with whom she is on good terms. Her mother appears as an aloof, cold queen—always poised and unbending. In an interview with the therapist, the mother disclosed her conviction that the patient is mentally deficient and hence needs firm guidance. The therapist's doubting of her opinion about her daughter's intelligence only confirmed her view that he was a fool who must be tolerated for the time being, since the patient insists on consulting him.

The only child born into this family of a middle socio-economic level, the patient grew up in a sheltered and restricted atmosphere. Due to the mother's concern over intelligence as an asset, emphasis was placed in childhood training on precocious mental development. The patient was taught to read and count at a very early age, but on entering school at five she showed only average ability. However, the mother continued to push her toward intellectual pursuits. The patient replied with a subtle but forceful resistance which the mother came to interpret as intellectual deficiency. Throughout high school she had few friends and no dates. Entering college, she suddenly became aware that something was amiss psychologically when she compared herself with her contemporaries. Her first outspoken defiance of her mother was to seek psychotherapy.

Further symptoms suffered by the patient are a feeling of being alone in the world, severe fears of night monsters, sensations of unreality, and ideas that people look at her queerly. Since she was nine when she developed a sudden panic at the thought that she was alone in the world, she has fluctuated between thinking that other people exist and feeling that they are only products of her mind.

Adolescence found her secretly investigating various religious and philosophic creeds in an effort to solve the problem. Unknown to her parents, she became a Catholic for a few years, but this also failed to quiet her wonder. The night monsters she fears originated in childhood and persist in a less intense manner up to the present time. She has difficulty going to bed and falling asleep because she begins to think the room is swarming with large, hairy spiders or that some type of octopus with teeth is creeping up on her. Ideas that people are looking at her and that her surroundings are unreal occur only when she is on the street.

In character structure the patient makes liberal use of compulsive mechanisms. She is orderly and perfectionistic about her room and clothes. But outside of concern for what she wears, she lacks interest in other activities, preferring to ruminate about the meanings of life and death, the real and the unreal, being and not being. She is reserved and shy, keeps her thoughts to herself, lets her mother make all decisions for her, and has little to say when spoken to, thus giving to others an impression of mental retardation. Her appearance and actions are those of an adolescent girl rather than of a woman her age.

The patient has a psychotic ego state in which her level of functioning represents mainly an arrest rather than a fixation. Psychotherapy can hope to help her grow further, diminish her withdrawal, and aid her reality-testing. The interviews now reported occurred over a period of months of therapy. The therapist's technique during this time involved concentrating on her feelings about people, especially her parents, and avoiding discussions of her philosophic preoccupations. Only once did she say anything about the therapist. Toward him she behaved girlishly, with a mixture of obvious admiration and a pinch of flirtatiousness.

Interview 10.

Today the patient begins by pondering out loud over the principles of an occult sect she has studied which believes the meaning of life lies in a correct appreciation of nature, especially trees. After some minutes of this, the therapist interrupts to bring the patient back to her daily reality life.

Ther.: Now tell me what you have been doing since last week.

Pt.: Nothing, really. I cleaned up my room, read a lot, tried some sewing. Day-dreamed most of the time. This idea about trees I gave a lot of thought to. There might be something in it.

She returns to her intellectual defenses against reality. Rather than get involved in the content of the tree philosophy, the therapist talks of the use the patient makes of it.

Ther.: Do you ever feel you are more interested in thinking about, rather than in living, your life?

Pt.: I don't have anything else to do but think. It passes the time. What else can I do?

Asking for advice which the therapist in this situation gladly gives.

Ther.: I feel it would help you to take up some regular activity, get interested in doing something. For instance, you mentioned once you would like to learn how to drive a car. Have you considered that again?

Pt.: I have. I'm not sure mother would approve. She's afraid I'm so nervous that I would have an accident. Could I have her call you about it?

Ther.: Why don't you discuss it with her if you're really interested? If there's any doubt in her mind, ask her to phone me.

Encouraging the patient to attempt mastery of a reality area, the therapist offers his support in dealing with her mother's possible objections. By offering advice of this kind he seeks to direct at least a small portion of her mental activity outward, away from inner abstract preoccupations.

Ther.: What sort of terms are you on with your mother these days?

Again influencing her to talk about interpersonal problems. The remainder of the hour she talked of her mixed love and resentment toward her mother. In general the interview is maintained on a supportive and conversational level. The next interview illustrates a bit of uncovering work.

Interview 26.

The hour opens with the patient's typical backwardness in starting to talk. The therapist shows his interest by immediately asking a question rather than letting her carry the burden of silence.

Ther.: What are you interested in talking about today?

Pt.: My loneliness, I guess. I feel I don't have anyone really close to me. I don't even want to see my old friends any more. They weren't really friends, just acquaintances I hung around with. They didn't do me any good, and I didn't like the way they lived. . . .

These were a promiscuous group of artists she had known for a short time in college.

Pt.: . . . The other day I met a girl I knew in high school and she invited me to her house, but I refused. She bores me. There's nothing we can talk about.

Ther.: Do you feel your loneliness is the outcome of your own activity?

Pt.: In a way. What do you mean by my activity?

Ther.: I mean that maybe you are lonely because you have removed yourself from people. Like with this girl.

Pt.: But that's only true in a few cases. A few people I don't like and avoid. The rest is because of my fear. I'm afraid to meet new people, strangers. Mother tries to get me to join clubs and go to parties, but I always make some excuse.

Ther.: What is it you fear from strangers?

Pt.: Talking to them. I can't think of anything to say. Then I know they'll think I'm a dope. When I meet someone I freeze. They're sizing me up. Sooner or later they will ask me what I am doing and I'll have to say "nothing." What should they think of someone who doesn't work, doesn't go to school, doesn't do anything but sit at home?

Ther.: So you fear they will look down on you.

Approaches the patient's projection of superego values onto others.

Pt.: They must. They think I'm worthless, inferior.

Ther.: Can you give me a specific example of meeting someone and feeling this way?

Thus far the discussion has concerned a general "they." By asking for details about a specific experience, the therapist focuses her attention on her feelings as arising from interpersonal relationships. She tells of trying to converse with a woman her age but failing because the woman was a college graduate and must have regarded as inferior those who were not. The patient then talked of her guilt about quitting school, since it meant she was a misfit. The therapist interprets her fear of people's opinion as fear of her own.

Ther.: It's interesting that the low opinions you fear others will have of you are exactly the opinions part of you has about yourself.

Pt.: You mean I assume others think the way I do?

Ther.: Yes. You ascribe to this college woman a view that is really your own. You regard yourself as a misfit for not finishing college and then project that evaluation onto people you meet.

The patient is shown one of her psychological mechanisms in the same manner as would be

attempted in a neurosis. No impulses are touched upon. Only defenses against projected superego anxiety are mentioned. This type of uncovering is permissible and valuable in such a case.

Interview 43.

At this point in therapy there have been a few changes in the patient's life. Freed of some of her social inhibitions, she has developed a friendship with a girl who is also learning to drive a car. The confidence gained through mastering an auto and increasing the range of her mobility in the external world have added to her hope that she can be like others. In the therapist she has found an ally she can depend on during her ambivalent anxiety in moving out from under her mother's thumb.

She mentions a dream of the previous night.

Pt.: Had a weird dream last night. I was in a bedroom somewhere. On the bed there was an older woman, naked, with some pearls around her neck. She put her arms out to me as if asking me to come nearer. Then another girl ran into the room with a hatchet or a cleaver and started hacking up the woman. I awoke with a start. What a horrible dream! Then all of a sudden I thought there was something in the room. I put the light on but nothing was there. What do you think the dream means? The older woman could be my mother. I have felt like killing her at times.

Too true to be good for this patient. The murderous, mutilative, and homosexual impulses in the dream should not be uncovered. The dream can be discussed briefly, using a technique of allaying anxiety by "naming it."

Ther.: When you woke up you were frightened by something that might be in the room to hurt you?

Pt.: Yes. Much like the fear I have when falling asleep.

Ther.: As you say, the dream might be an expression of normal death wishes that we all have toward our parents at some time or other. And the fear of something hurting you would be the fear of punishment for those death wishes. Maybe those things you fear when you go to sleep represent severe punishments for what you feel are sins.

Explaining, psychologizing, and implanting intellectual defenses.

Pt.: They began when I was small, and I certainly had a great fear of punishment then. Not physical punishment, but being scolded and criticized. My mother could make me feel guilty just with a glance, even when I hadn't done anything.

She continues in the direction of describing some of her life as a child and the various means she evolved to deceive or oppose her mother.

Interview 65.

This interview is selected because this is the only time that the patient's feelings toward the therapist were mentioned. Thus far in therapy the situations which in neuroses would require transference interpretations, i.e., intercurrent resistances, have been managed by interpositions alone. But in this hour the patient seems unable to overcome a reluctance to speak, even though helped by questions from the therapist. Applying the principle of bringing up the transference when confronted by a strong resistance, the therapist begins.

Ther.: You seem a little reluctant to talk today.

Pt.: I suppose so.

Ther.: What do you think the reason is?

Pt.: Can't think of much to say. I'm all talked out.

Ther.: Maybe it has something to do with me.

Pt.: What do you mean?

Ther.: That you are reluctant to talk because you have something on your mind regarding me.

Pt.: No. I don't think so.

No success, so the therapist tries a different angle of approach.

Ther.: Even if it isn't on your mind now, what have been your thoughts about me?

Pt.: Oh, I've had all kinds. At first I didn't trust you. Especially when I thought you would tell everything I told you to my mother. That's what another doctor did once. After you saw my mother, I quizzed her about it and compared what she said to what you said was talked about. It was close enough so that I trusted you a little more. But even nowadays sometimes I wonder how much I should tell you.

Ther.: Is it only that you're afraid I'll tell your mother what we talk about?

Pt.: Not entirely. I worry how you will react. Whether you will ridicule me or look disgusted with me.

Ther.: Whether I'll react like your mother?

Pt.: I suppose so. Another thing I feared was that you had dictaphones in here or a camera taking a picture.

Ther.: What made you think of those things?

Pt.: Sometimes I hear a whirring noise as if a machine was running.

Ther.: Oh, that's just the ventilating system going on and off. There are no cameras or dictaphones in here.

He explains the reality factor and ignores pointing out the mildly paranoid aspects of her thinking. Returning to her distrust:

Ther.: And today is it that you are wondering if you can trust telling me something?

Pt.: This isn't trust so much as a fear of your reaction. So you must know what it is.

Ther.: No, I don't.

Pt. (*with great hesitation*): Well—it's sex. To be more specific, masturbation.

Her first mention in six months of a sexual topic. The patient continues to talk of her anxieties about infrequent masturbation. The transference in this instance is hardly explored beyond the connection between therapist and mother. However, with the resistance removed for the time being, further transference discussion is not required.

A therapist, sharing our culture's rush for change, may become disheartened in treating schizophrenia when immediate improvements are not forthcoming. But many psychotic ego states are reversible, requiring only patient psychotherapeutic work over a long period of time. In fact some of the best results effected by psychotherapy can be achieved in these cases.

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