Psychotherapy with "Schizophrenia": Analysis of Metaphor to Reveal Trauma and Conflict

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Actually, often the only thing "wrong" (as it were) with the so-called schizophrenic is that he speaks in metaphors unacceptable to his audience, in particular to his psychiatrist... When persons imprisoned in mental hospitals speak of "rape" and "murder", they use inappropriate figures of speech which signify that they suffer from thought disorders; when psychiatrists call their prisons "hospitals", their prisoners "patients", and their "patients'" desire for liberty "disease", the psychiatrists are not using figures of speech, but are stating facts.

Thomas Szasz (1976, p. 14)

Meanings alter in the service of emotional needs; and when a person's acceptability to himself and others is threatened, when no way out of an irreconcilable dilemma can be found, and when all paths into the future seem blocked, there is still a way. One can simply alter his perceptions of his own needs and motivations and those of others; one can abandon causal logic or change the meanings of events; one can regress... In short, one can become schizophrenic.

Communication is of the essence, and the patient is weaned from his autistic preoccupations and his idiosyncratic communications by the therapist's ability to hear and understand what the patient wishes to say even while he seeks to conceal through the use of idiosyncratic metaphor and cryptic associations.

Theodore Lidz (1973, p. 10 & p. 103)

[some would have us] ...turn relatively quickly to the latest information from such scientific fields as behavior genetics, biochemistry, psychopharmacology, epidemiology, and so on to find reassuring evidence that the schizophrenic patient is, after all, qualitatively different from truly human beings; so that it is pointless to risk one's own sanity by persisting in this disturbingly conflict-ridden effort to work psychoanalytically with him.

Harold Searles (1975b, p. 226)

...even the most "crazy", manifestations of schizophrenia come to reveal meaningfulness and reality-relatedness not only as transference-reactions to the therapist, but, even beyond this, as delusional identifications with real aspects of the therapist's own personality...

Harold Searles (1965, p. 34)

One can repeat specifically with respect to the psychoanalytic therapy of schizophrenia, as well as other psychosocial treatments, Freud's comments about psychoanalysis, that, in Mark Twain's words, "The reports of my death are greatly exaggerated."

Bertram Karon (1989, pp. 146-7)

Let's imagine that we have just begun seeing a young man in therapy after he has ended a program with another therapist. He comes late to an initial session, mentioning that he was delayed trying to visit his old therapist, but she wasn't there. If he next mentioned that he'd heard a news story about a woman who abandoned her baby in a dumpster, stating that he thought she should be shot, we might begin to hypothesize that the vignette about the baby held some relevance to his feelings about his current situation. This hypothesis might be strengthened if his other comments seemed to coalesce around similar themes, such as telling you how silent you've been, or criticizing inhospitable aspects of your office.

In this regard we might be informed by the writings of Harold Searles, Robert Langs and others who view a patient's verbalizations as frequently being thematically relevant to the therapeutic context, or as being unconscious supervision. These and other writers alert us to attend to the metaphorical and thematic relevance of the patient's associations -- with particular reference to the current state of the therapeutic relationship -- and therefore to put less emphasis on the manifest content of what is said. Given this perspective, we would not be put off from our therapeutic task if the client used metaphors that we judged to be unrealistic on a manifest or surface level. For example, they might state that they were a baby in a dumpster, or tell us that they were an aborted fetus. Or perhaps they might tell us that they were a crew member on the spaceship "Juan Doe". Only later we might learn that "Juan Doe" was the name of the infamous "garbage barge" that was denied entry to numerous ports. If we made this simple transition to listening thematically and metaphorically, and to listening without undue emphasis as to whether what was said sounded "unrealistic", "psychotic" or initially incomprehensible, we would be doing what we have been told we can't or shouldn't do -- therapeutic exploration with people whom we typically call "schizophrenic".*

* (footnote) Language can both communicate and conceal. Throughout this paper I use quotation marks to demarcate certain commonly used psychiatric terms and concepts that connotatively perpetuate a perspective that I wish to call into question. The quotations serve as a reminder to the reader to question certain problematic assumptions that I believe develop from our uncritical use of those terms.

Focus of this paper

This paper aims to resurrect debate about several questions related to the conditions commonly known as "schizophrenia" or "psychosis", and to point to clinical and research evidence which suggest that our current predominant models for understanding these conditions may be blinding us to other, more cogent, perspectives for understanding them. Specifically, our reliance on the imagery of "mental" or physical illness and disease has contributed to discounting a more linguistic, narrative or metaphorical analysis of the communications that we label as "psychotic symptoms".

My own conviction in this regard is directly linked to my experience as a psychotherapist. With great regularity I have found it increasingly possible, throughout the course of discussion

(therapy) with a "psychotic" person, to understand certain symbolization used in their talk, and to see how such poetic or camouflaged language may relate quite compellingly to previously unexplored personal dilemmas or conflicts, or to previously undisclosed trauma. With regularity I have seen that once reasonable attention and discussion is devoted to those metaphorical uses of language (what might be called the "symptoms": the "thought disorders", "delusions" or "hallucinations") and to their referents (the traumas and conflicts), that the "symptoms" fade from prominence, and are replaced by a more direct discussion of the problematic traumas and conflicts themselves.

But though these therapy experiences form the basis for this paper, I will first present some more general criticisms of the "mental health" professions' prevailing and predominant approach to the problem of "psychosis", in order to show just how tenuous and unsupported those more biological attempts at explanation are. Some organizations urge us to define some behaviors as "symptoms" of "mental illness" or of a probable but as yet unproven brain disease. We are exhorted to "learn to see the sickness" (as in one prominent advertising campaign). But I propose that this is akin to being urged to learn to see the emperor's new clothes. That is, we are being urged to blind ourselves to the "nakedness" (the lack of substantiation of the medical metaphors and hypotheses), just as we are being urged to ignore how some people (the "psychotic patients") are trying to communicate (albeit ambivalently and in a camouflaged manner) with us.

We must remember that people receive the diagnosis of "schizophrenic" or "psychotic" on the basis of their words or behavior, not based on the status of their brains. It is, of course, not impossible that future medical research will show us some substantive substrate of explanatory biological fabric for "psychosis". However, we should not lose sight of the fact that we are being exhorted to see what is not yet established (that these are at root medical "diseases"). We are being tacitly asked to collude in ignoring certain alternative and, I believe, cogent explanations ("naked facts") which we also could see in front of our eyes.

In the Hans Christian Andersen tale, the strategy used by the tailors to gain compliance with their shared falsehood was to let it be known that those who could not see the fine clothes they were producing for the Emperor were either fools or unfit for their posts. Similarly, we can see parallels in the subtle coercion of the "mental health" professions. We are exhorted and pressured to see the "sickness", the "mental illness", and to use language suggesting disease, disability, mental incompetence, insanity and biological illness. We are inherently asked to blind ourselves to the possibility that there is camouflaged communication in what the people we call "psychotic" are saying to us; and to the possibility that there may be meaning in their "madness".

Questioning "Schizophrenia" as a Disease

The conception of "schizophrenia" as disease is questionable from several perspectives, some simply by analogy or comparison. Elsewhere in work with troubled people, we accept that people can say things which we don't comprehend at first, can make statements which seem manifestly at odds with reality, can deny certain accepted assumptions about their identity, their

experience or their memory. They can do these things in a way which seems bizarre or initially inexplicable to a "rational" or relatively "objective" observer. Yet we need not resort to exclusively or predominantly medical hypotheses to explain such discrepancies. For example, in the condition typically termed "multiple personality disorder", a person may tell us that they are five years old and named Sue, or five minutes later, that they are 30 years old and named Sylvia. They may state that these two entities have distinctly different memories and experiences and no knowledge of each other. Since these descriptions are at odds with what we call consensual reality, they could be labeled "psychotic".

The literature on this form of human functioning and experience (or "psychopathology") points with near unanimity to potentially formative childhood experiences which help account for these "psychotic" descriptions. Such childhood experiences are commonly known and documented by now. Typically they involve repeated and cruel infliction of torture, sexual and physical abuse, or exposure to a traumatic event such as the witnessing of the violent death of a loved one (Putnam et al, 1986). These powerful personal experiences, many of which are secret or unrevealed at the outset of therapy, help us to understand how "psychotic" characterological configurations could be comprehended as adaptations to overwhelming stress. They are "psychotic" configurations in the sense that people describe their identity and experience in ways which are manifestly at odds with consensual reality. As Rosenberg (1984) has pointed out, we call actions, behavior or people "psychotic" when we initially can't comprehend their logic or point of view, and when we conclude that they are inherently incomprehensible.

There has been some evidence of physiological correlates of aspects of multiple personality disorder (Braun, 1983), and I am not arguing that researchers should not investigate any human problem from any perspective (sociological, chemical, anatomical, religious, economic, etc.) which could conceivably prove illuminating or helpful. But certainly the case of "multiple personality disorder" alerts us to the potentially central importance of linguistic, psychotherapeutic, narrative or experiential studies of people whom at first we might label "psychotic" (since we have not yet made sense of their words and behavior). Along these lines, Sarbin (1986) points to the dangers of tacitly accepting a mechanistic or positivistic approach to science, which may then preclude productive contextualist or narrative explorations that can contribute to our understanding of psychological phenomena.

Given what we know of "multiple personality disorder", we might then posit that people adapt to stress in different ways. Some people get headaches, some get anxious, some become sad and forlorn, some take their frustrations out on others, and some people talk or describe themselves in ways that at first seem incomprehensible to others, or report having experiences that seem inexplicable or unrealistic ("psychotic"). Certainly reports of "hallucinations" by hostages who have been isolated while their lives were threatened seem to support these inferences (Siegel, 1984).

Those who promulgate the metaphor of "mental illness" usually ignore or deemphasize "diagnostic" categories which link clear experiential precipitants with the "illnesses". We are less likely to hear "multiple personality disorder" or "post-traumatic stress disorder" described as diseases or "mental illnesses". Instead, the term "mental illness" tends to be applied to situations in

which peoples' behavior or statements about themselves initially appears to be perplexing or unexplained in terms of their life experience. Such medical language often implies that there is some unspecified biological disorder, or perhaps some biological marker which is yet to be discovered, which would account for the unusual, disturbing or incomprehensible thoughts or behavior.

In fact, Thomas Szasz's (1976) critique of the conceptualization of "schizophrenia" as a "disease" emphasizes this frequently and conveniently forgotten link in reasoning about "mental illness": the typical medical model of disease elucidation involves confirmation of the histopathology (tissue pathology) or malfunction that underlies some humanly unwanted or deleterious symptom or complaint. He notes that in the case of "schizophrenia", no underlying tissue pathology has ever been demonstrated. Instead, the "discovery" of the disease rather was its "invention", when attention was called to a cluster of behaviors which seemed to frequently coexist.

Elsewhere, Szasz (1987) incorporates the evidence compiled by the "experts on diseases of the body, ... pathologists". He cites pathology textbooks to show that although "ever since the earliest days of psychiatry, psychiatrists have claimed that mental diseases are brain diseases; that pathologists have never been able to confirm these claims " (p. 71, emphasis in original). He concludes that "psychiatrists ought to convince pathologists that schizophrenia is a brain disease before they take it upon themselves to tell the public that it is such a disease or try to silence those who disagree with them on this crucial issue" (p. 73).

The central point here, which we frequently keep ourselves blind to, is that no one has ever been diagnosed as "psychotic" or "schizophrenic" on the basis of anything other than a judgment of their words and behavior. Neither a CAT scan, an autopsy nor a test of neurotransmitters has ever been used to diagnose this "disease", nor could they be, because there is no such demonstrated or reliable biological substrate. Burrell (1992) has pointed to the specification of the DSM-III-R, noting that "schizophrenia" can only be diagnosed when... "It cannot be established that an organic factor initiated and maintained the disturbance" (p. 192). Alternatively, "when a person presents with symptoms characteristic of Schizophrenia, the diagnosis can be made only when the clinician concludes, after an appropriate evaluation, that no organic factor (such as a psychoactive substance or a brain tumor) can be established to have initiated and maintained the disturbance" (p. 22). (See also Szasz (1987) on this issue.)

What Szasz articulates as a logical critique of our blind acceptance of the term "schizophrenia" as a disease, Sarbin and Mancuso (1980) reinforce through their critical review of much of the prominent recent literature which purports to support the viability of "schizophrenia" as a useful and distinct psychological term, and the literature that is usually cited to substantiate the view that "schizophrenia" is a medical diagnosis with a biological substrate. Like Szasz, they emphasize that repeated attempts to scientifically shore up the diagnostically distinct psychological concept of "schizophrenia", or to find definitive or replicable biological markers of any tissue pathology, have consistently failed. Among other powerful critiques, they point out the regularity with which researchers who claimed to have identified a psychological or biological correlate of "schizophrenia" were generalizing from published findings of small but statistically significant

differences between the arithmetic means for groups of "schizophrenic" and "normal" samples. There were often substantial overlaps in the data for each group, and often great variability in the data within the "schizophrenic" samples. The authors point to the fallacy of assuming that such findings, which were not routinely replicated, supported the notion that the groups could be definitively differentiated by use of the variables being studied. Many of these studies violated fundamental tenets of research by failing to control for disguised aspects of the experimental context, such as the use of major tranquilizers, or they failed to control for other potentially intervening variables, such as intelligence, level of education, the effects of institutionalization or patienthood experiences. I will not summarize their work here, but I urge that their critique (Schizophrenia: Medical diagnosis or moral verdict?) be read by those who tacitly accept the disease model of "schizophrenia" as being either logically appropriate or confirmed by research. Sarbin later summarizes and extends these arguments (1990, 1992).

Similarly, Bentall, Jackson and Pilgrim (1988) review prominent psychiatric research and conclude that there is strong reason to consider other approaches to studying the amorphous and indiscrete phenomena we call "schizophrenic". Their review convinces them that, "Not only is it impossible to decide whether schizophrenia is a disease or a form of social deviance without first identifying such an entity, but no meaningful research can be carried out comparing schizophrenics to others without first establishing the reliability and validity of the schizophrenia diagnosis" (p. 305). After reviewing the inconsistent neurological, biochemical and psychological research, they emphasize the lack of usefulness of "schizophrenia" as a scientific category. They remind us that the "history of science is littered with examples in which progress has been impeded by the continued use of invalid categories leading to the persistent asking of the wrong questions" (p. 317). The authors point to economic, political and primarily guild interests (mostly involving organized psychiatry and psychology) which may perpetuate such invalid diagnoses. These same interests may promote a relatively blind "article of faith" in the potential for future, more refined research to eventually document the validity of "schizophrenia" as a label or as a medical/biological diagnosis or entity. Their review argues for "abandoning the 'schizophrenia' concept" in favor of research into more discretely identified "psychotic symptoms". Persons' (1986) paper, "The advantages of studying psychological phenomena rather than psychiatric diagnoses" makes similar and complementary arguments.

Boyle (1990) goes into great detail to review flaws in logic and research design in many studies which profess to strengthen the concept of "schizophrenia" as a valid psychological or diagnostic category, or especially to portray it as a disease. In one chapter of her book Schizophrenia: A scientific delusion?, she critically reviews the claims of evidence for a "genetic" factor in schizophrenia based on adoption and twin studies, revealing the paucity of research support for the predominant biological claims. She, like many authors cited here, also questions "Why has /the concept of/ 'schizophrenia' survived?". Similar critiques of the research claiming to establish the biological basis of "schizophrenia" are available (Breggin, 1991; Cohen, 1989; Cohen & Cohen, 1986; Karon, 1991; Karon, 1992; Lidz, 1973; Lidz & Blatt, 1983; Rose, 1984; Sass, 1992).

Breggin's (1983) critical review of a segment of the literature on major tranquilizers

undermines a corrolary to the medical model of schizophrenia. He points out the historical falsification of the effects of major tranquilizers that led to their inaccurate labeling as "anti-psychotic" drugs. By reviewing key research and recounting the historical derivation of these drugs, he shows how their primary effect is tranquilizing, sedating, or in his estimation "brain-disabling". He demonstrates that, far from being a specific treatment for a supposedly identifiable neurochemical malfunction or disease, these drugs are cognitively repressive and disorienting agents that affect all people ("normal" or not) as well as animals. He points out how other medical specialties recognize this; only within psychiatry are these drugs relabeled and promoted with claims that they are a specific treatment for a specific illness. For example, in emergency medicine, major tranquilizers are recognized as a sedating agent for any uncontrolled, disruptive or belligerent patient (Clinton et al., 1987).

Breggin's (1991) Toxic Psychiatry also summarizes and critiques aspects of the literature which purport to identify "schizophrenia" as a disease, or to portray major tranquilizers as specific remedies for that disease. He supports the reasoning of Sarbin and Mancuso (1980) by pointing to evidence that the abnormalities that sometimes have been shown to statistically differentiate groups of "schizophrenics" from normals on brain scans, or with regard to neurotransmitters, are probably not innate anatomical or chemical markers of "schizophrenia". Instead, he argues that at least some of those abnormalities are evidence of the iatrogenically-induced damaging effects of major tranquilizers, particularly associated with long term consumption.

Rappaport et al (1978a), in examining research evidence of "schizophrenics for whom drugs may be unnecessary or contraindicated" (p. 100), summarize findings of phenothiazine effects "such as decreased sensory and psychological sensitivity, decreased problem-solving ability and a decreased ability to learn" (p. 107). In another review of evidence questioning whether these drugs are more than "palliative", Rappaport (1978b) reviews "instances in which the use of antischizophrenic medication has little or no effect and where its use is probably unnecessary" (p. 223). He states that "the numbers of individuals involved cannot be considered by any stretch of the imagination to be insignificant" (p. 223). Though he later concludes "that antischizophrenia drugs are extremely valuable in favorably modifying unwanted psychological symptoms in some patients" (p. 229), his review also reconfirms "patient complaints about being 'held down' or being in a chemical straitjacket" (p. 223). Cohen & Cohen (1986) acknowledge that many "patients" take such drugs willingly because "they feel that the calming effects are worth a degree of discomfort or diminished alertness" (p. 23). However, they underscore Coleman's (1984) crucial distinction: "it makes a difference whether a patient takes drugs because he or she finds them helpful or because the patient believes that modern science has discovered a brain abnormality that can be treated with drugs" (Cohen & Cohen, 1986, p. 23).

I have witnessed psychiatrists warning colleagues to not openly use terms such as "chemical restraints" or "major tranquilizers" in describing such drugs, for fear that certain psychiatric practices might be criticized. So, we are marshalled to deny what we see. But who among us in our professional work has not seen these drugs used for just that purpose -- to subdue or sedate unwanted, unruly or initially incomprehensible behavior? Why is it that in some areas of psychiatric practice we are pressured to describe these drugs in a biased manner? Again we can see

the relevance of the "Emperor's New Clothes" metaphor. Those who disagree with the conventional view of "anti-psychotic" medication are seen as "fools" or "unfit for their posts".

Breggin (1991) also provides a lengthy historical and investigative description of the guild competition among mental health professions, and particularly of the increasing corporate alliance between the profession of psychiatry and the pharmaceutical industry. Those two groups in particular can have a mutual interest in describing human problems of confusing, disturbing or disruptive behavior as if they were primarily reducible to organic malfunctions. However, as we have seen, such organic substrates are neither consistently substantiated by research nor confirmed in the particular "patient". Yet, those theories do provide the rationale for the use of medication (which Breggin continues to demonstrate, provides a basically "brain disabling" effect), and a rationale for the position of psychiatry as the authoritative force in explaining and managing troubled or troubling people within society.

Along similar lines, Scull (1975) supplies an informative historical account of how, in the nineteenth century, "that segment of the medical profession which we now call psychiatry ... acquired a monopolistic power to define and treat lunatics" (p.218). He points out that there was at that time "a lack of any real knowledge base which would have given the medical profession a rationally defensible claim to possess expertise vis-a'-vis insanity" (p. 222). Hence certain implicit parallels may be drawn historically and sociologically to the professional debates and guild interests of our own time. Since the period Scull describes, it has been "the psychiatrists /who/ possess the ultimate power to assign one person to the status of being mentally ill, and to refuse the designation to another" (p. 221).

Leifer (1990) and Breggin (1991) describe instances in which vocal critics of these biological theories and disease models have been threatened and censured, both by curtailment of teaching opportunities and terminations of employment in academia, and by attempts to strip professionals of their licenses. Colleagues inform me that biologically-oriented professionals experienced similar professional repression in the past, when psychosocial and psychoanalytic theories were more ascendant. Clearly, such squelching of debate and academic freedom is reprehensible in the service of anyone's views, and it is scandalous in terms of what information it provides and denies both to the public and to relevant clinicians.

Some psychosocial perspectives on "psychosis"

Some writers have tried to make sense of "psychotic symptoms" from a more experiential perspective. Bettelheim (1956) worked with "psychotic" children and began to wonder about the sense of terror, the emotional and cognitive confusion, and the distortions of reality he perceived. He realized that he had seen such reactions previously in concentration camp inmates and survivors. He began to conceptualize these "symptoms" as "reactions to extreme situations", by which he meant traumatic and overwhelming situations from which the person could not withdraw or escape. Support for such observations comes from other clinical areas. For a considerable time we have had documentation of traumatic combat situations which provoked "psychotic symptoms" (e.g.

Grinker & Spiegel, 1945). Dohrenwend and Egri (1981) provide evidence that "symptomatology of schizophrenia observed in combat situations is indistinguishable from the symptoms of schizophrenia observed in patients from civilian populations" (p. 17). They describe the stresses attendant to "prolonged exposure to heavy combat", reminding us that these "extreme situations" involve a loss of control in experiencing the "death of comrades, threat of one's own death or disablement ... and being stripped of ... social support" (p. 18).

Similarly, Siegel's (1984) inquiry into hostage situations which led to hallucinatory experiences, suggests that these experiences derive from "conditions of isolation, visual deprivation, restraint on physical movements, physical abuse, and threat of death" (p. 269). In attempting to understand which of the hostages had "hallucinations", he finds that "the critical combination appears to be the presence of both isolation and the threat of death" (p. 270).

Earlier in this paper, I pointed out the regularity with which people described as exemplifying multiple personality disorder later revealed excruciating instances or ongoing experiences of childhood trauma or abuse. In describing the evolution of his observations about life situations which contribute to "schizophrenia", Lidz (1973) states:

> Then, I noted during my residency that all of the schizophrenic patients under my care came from disturbed or very peculiar families. Indeed, sometimes after spending an hour or two with one or both of the patient's parents, I would wonder just how long my sanity or anyone's sanity would withstand living with these people, to say nothing of being raised by them.
>
> (p. 8)

> Interest in the family milieu in which schizophrenic patients grew up was stimulated further because close relatives of several patients, who had not been taught that we were dealing with a disease of unknown etiology, ignorantly explained to me just how the situation in the patient's family had driven the patient crazy. (p. 9, emphasis added)

Where Freud had conceptualized his patient's reports of incest as oedipal fantasies, Lidz's observations with these families led him to very different conclusions. Lidz's evidence suggested that "when not reflecting actual experiences, such reports occur when the patient's fantasy had been stimulated by a parent's near incestuous behavior or attitudes" (p. 112, note).

Karon (1991) expresses somewhat similar observations. He cites the research on "expressed emotion" (see for example Leff & Vaughn, 1980) and "parental communication deviance" in families of "schizophrenic patients" (research which is often associated supportively with Lidz's views), and continues:

> In no case have I ever treated a schizophrenic whose life, as experienced, would not have driven me crazy. Where the therapeutically reconstructed material concerned externally observable events, it has been possible to confirm them. It is not isolated traumata, but continuing pressures, mediated through the resulting conscious and unconscious fantasy structures, which make human beings vulnerable. Whenever the family environment was

> unfortunate and the individual did not end up psychotic, there were always people outside the family who provided corrective identifications and experiences. Whenever the family environment was not unfortunate and the individual ended up psychotic, there were always traumatic experiences outside the family which were overwhelming. (Karon, 1991, p. 8)

He states his clinical experience that "in every case there are parent-child interactions, whose consequences are hurtful, but different overt behaviors occur in different families" (p. 7). But he also emphasizes that in previous theorizing and research, portrayals of "the schizophrenegenic mother were over-simplified and gross". Earlier (Karon & VandenBos, 1981) he had devoted considerable effort to contradicting the accusatory or guilt-ridden view that parents of "schizophrenics" were simply "criminal" or "evil". Lidz agrees:

> The patient's illness is far more tragic to the parents than to the therapist, and their noxious influences upon the patient were not malevolent but rather the product of their own personal tragedies and their egocentric orientations. (p. 122)

Rosenberg (1984) examined the use of the term "insane" by experts and laymen, showing that both groups label a person's behavior or speech "insane" when they are unable to account for the protagonist's behavior from that person's perspective. However, Karon and VandenBos (1981) supply case examples of therapeutic exploration of "schizophrenics'" seemingly insane or incomprehensible verbalizations. They demonstrate that it is not an impossible task to begin to decipher some of the symbolism involved. For instance, they describe the case of a man who was frequently seemingly unprovokedly violent, who was often incoherent or silent, and who stated cryptically, "You swallow a snake, and then you stutter; you mustn't let anyone know about it" (p. 38). The authors show how verbal and symbolic investigation revealed that as a child this man had been regularly choked by a family member, had been incestuously raped, and later was orally/sexually involved with a priest. These experiences previously had been secret and undiscussed, and contributed to the man's subsequent speech impediment, as well as to his other formerly inscrutable behaviors and verbalizations.

The Karon and VandenBos book is recommended to any student of psychotherapy with "psychotic" patients, both for the illustrative symbolic case examples they discuss, and for their larger psychotherapy outcome research that documents the efficacy of psychotherapy in such situations. Additionally, they examine critical flaws in most of the previous psychotherapy research which had seemed to demonstrate the inefficacy of psychotherapy with "schizophrenics". Previous research frequently ignored the inexperience of the therapists and supervisors studied, often utilizing residents or therapists who had little experience with such "patients". Previous studies also used therapists who were involuntarily recruited to do psychotherapy with psychotic patients. Other flaws cited were the absence of either blind evaluation, or of long term follow-up measurement in the studies. Karon (1989) later updates and expands his critical review of studies which have compared the effects of psychotherapy with those of medication in working with "schizophrenics".

However, much as I urge critical reading of these cited works, it was not reading them that convinced me of the efficacy and importance of psychotherapeutic exploration of "psychotic"

verbalizations or other "symptoms". Instead, I was first convinced through experiences in psychotherapy that were similar to those of Karon and VandenBos.

Illustrative therapy sessions

First, let's consider some vignettes from a therapy session with a "non-psychotic patient". (The following case examples are disguised for reasons of confidentiality). The man described at the beginning of this article had been in outpatient therapy with me for several months when he came to a session late. He said that he had stopped by his old therapist's office, but he had just missed her. Next he described a recent news story in which a woman had given birth to a child and had left the baby in a dumpster. He felt that she should be shot. He then mentioned that in his carpentry work he'd recently dealt with a customer who had moved into a house that was under construction and was not complete yet. He told me what a "dumb move" he thought that was. Then he pointed out that I wasn't saying much. I was reminded that more than once recently he had mentioned clocks or watches that "worked when they want to". I pointed out that he had mentioned not seeing his old therapist; that imagery had come up about a mother abandoning a child, and about someone going into a new situation that wasn't really prepared adequately, and that he'd referred to my quietness. I said that it made me wonder if there might be parallels between what he'd said and the situation of leaving his old therapy and starting with me. After being quiet for a while he shrugged as if to dismiss my comment, and then began to speak of a guy he'd paid to fix his car. He said that the guy had done a pretty good job, but then he'd jammed in a part, damaging the trunk. I thought it best to be quiet.

Many of us are exposed to this manner of listening in therapy. It is a conceptualization of the associations or verbalizations in therapy as being expressive (perhaps on an indirect or "unconscious" level) of the emotional reactions of the client, and perhaps with particular relevance to situations in the therapy. In this approach to psychodynamic understanding, most prominently discussed by both Searles and Langs, particular attention is given to seeing client communications as "derivative commentaries" (Langs, 1976) which express the client's emotional reactions to actual actions and attitudes of the therapist. From this perspective, the patient's associations are seen as unconscious supervision by which "the patient is therapist to his analyst" (Searles, 1975a). In the session just described, I believed that this man's associations may have held some relevance to his reaction to me and my seeming lack of involvement in the therapy. His subsequent vignette may also have expressed his reaction to, and partial criticism of, my comment. That is why I decided to be quiet. In later weeks, I noticed that that this man spoke regularly of his tendency to jam on his brakes when driving on the highway, whenever he sensed he was being followed too closely.

In this approach to listening in psychotherapy, it is not of primary importance whether something a patient says is factually or realistically true or accurate. The job of the therapist is not conceptualized as being a judge of the ("manifest level") literal truth or accuracy of statements. Instead, statements are examined to try to appreciate levels of feeling and communication that may be more subtle, or harder to describe, more complicated, conflicted or ambivalent, perhaps less categorical, perhaps more dreamlike, more awesome, emotionally poignant, or unspeakable.

In the clinical situation just mentioned, the imagery of a car following too closely, or of something being jammed into someone's trunk, turned out to be a very apt symbolic or poetic expression of a central concern of this man. These images foreshadowed a gradual direct discussion of very real and formative traumatic sexual experiences he had had which contributed heavily to his difficulties with men in particular.

But once emphasis is given to listening to therapeutic communications from a metaphorical, symbolic perspective, any preoccupation with judging the literal accuracy of a person's statements becomes irrelevant. If a patient in a session chose to tell us that they were a baby in a dumpster, rather than simply relating a news item with a similar theme, should we abandon the search for the potential underlying meanings of such an assertion (since we judge the communication to be literally not true, and hence "psychotic")? Why would we understand the statement to be so radically different from what this man said to me?

By way of further comparison, in trying to understand a dream, we may scan the descriptions for potential personal or idiographic meanings, or their relevance to current situations. But most therapists wouldn't consider criticizing the seeming illogicalities of the dream imagery as a way of invalidating potential relevancies of the dream. Why would we therefore stop the search for metaphorical relevance in client communications generally, just because the communications may seem implausible, unrealistic, or "psychotic" on a manifest level?

Here is a brief example. A woman applied to return to therapy in the clinic where she had seen a male therapist years before. He had left the clinic and she had continued to work with him in a new setting. Part of the therapy had focused on her past history of sexual abuse. The therapist had encouraged her to confront her family about this secret. When she failed to follow some of the suggestions he felt were most important for her, he ended the therapy. She returned to the old clinic for an intake interview. To be helpful, the old therapist spoke with the intake worker, reviewing the course of the therapy and discussing the referral. In the intake interview, the patient spoke about her father. She said he ran a prostitution ring, and she also believed that he called ahead to any stores or other places where she went. She said that wherever she went, people had already been contacted by him.

In a subsequent staff meeting, the woman was given a psychotic diagnosis. The staff reasoned that there was no evidence in reality that her father ran a prostitution ring, and that her other concern, that anyone she met had already been contacted by him, seemed "paranoid". There were suggestions that she would only be appropriate for "treatment" by "medication" and not by "therapy".

Instead, the patient's cogent metaphorical communication describing pimping and procurement might have alerted staff to ways in which the actions of the previous therapist and of the intake worker may have been recreating traumatic patterns reminiscent of her sexual abuse. We might remember that the previous therapist had tried to run her life, at least to some extent, and he had eventually terminated her therapy when she wouldn't do what he said. Her reference to her father's intrusive communication similarly might have poignantly expressed her sense of violation

or contamination at the communication between the old therapist and the intake worker.

Here is a condensed clinical example of how "psychotic" communications may be explored for their metaphorical relevance. I saw a young man in therapy who had recently been hospitalized on several occasions, in part for his disruptiveness and "hyper-religiosity". He had begun to stay up late at night, while living in his mother and step-sister's home, and he would preach to them from the Bible because he felt that he needed to get them to change. He thought perhaps he was Jesus Christ. At times he would be silent for long periods of time. He also said he sometimes had visions of people's faces being mangled or crushed. Only much later did he add that they were often the faces of his family.

Over the course of some family therapy sessions the man spoke of the devil being in his house, though some people might not know it, or might not want to talk about it. Certain sexual references were made as he described the devil coming into peoples' rooms at night. When such imagery had recurred, I questioned whether any devilish or sexual secrets had actually gone on in the home. Eventually, when this symbolism and my question had come up more than once, the step-sister asked if I meant something like the time she had put rubber bands and clamps on his genitals. She eventually revealed that she had secretly physically and sexually abused him for an ongoing period of time when they were left alone as children. She also related these acts to the beatings her mother secretly had given her. These revelations came out quite haltingly, over a long period of time, and were accompanied by expressions of her fear that she was responsible for driving her stepbrother crazy. She hinted repeatedly at her guilty feelings and looked to the patient for some confirmation or disagreement. He would avoid eye contact and become silent at such times. When pressed, he denied that she had hurt him, telling me privately that such abuse couldn't have happened because he didn't have a step-sister.

At one point the young man was required to have an appointment with a psychiatrist. He insisted to me that he did not want to be returned to prescriptions of major tranquilizers. I emphasized that he should feel free to tell the psychiatrist how he felt. When he had that meeting, it was noted in the chart that the man had said little and was seen as "catatonic", and that the psychiatrist next met with the man's mother and privately gave her medication for him.

At the next meeting with the family, the client began to speak of how he had cut up vitamin pills and had given them to a young relative to drink, unbeknownst to her, mixed with her juice. As he continued to talk, imagery of poison came up, and of coercion. His mother insisted that he was "talking crazy", and that no such events with juice and vitamins had happened. I suggested that perhaps his comments were relevant, pointing out the potential parallel with what had evidently happened with the psychiatrist, the mother and the medication. He then produced numerous stories of lurid, illegal and sometimes sexual activities that occurred around his home, that he knew of and that others either didn't know of or didn't want to speak of. Eventually the discussion led back again to the sexual abuse that had never been fully discussed. The mother discounted and disparaged her son's remarks, pointing out the manifest illogicalities in some of the stories he told. She hinted that she didn't want to continue such discussions, while simultaneously complaining that her son's feelings were "too bottled up" and that he didn't communicate enough. The step-sister, in

the mother's absence, later revealed other previously secret incestuous contacts which had occurred in the family years ago, between other adults and herself and other children.

Here is another clinical example. I worked with a young woman who felt confused and vague about what her problems were, and why she had made several suicide attempts. She had been hospitalized numerous times and was viewed as "psychotic" each time. For months at a time she told me that it seemed inexplicable that she kept repeatedly and inescapably thinking of a guy in a leather jacket. She insisted that those thoughts were her only problem. However, she often had been hospitalized when she was very upset and felt certain that others were trying to kill her. She had told me that she had started years of intermittent hospitalizations following her father's abrupt death when she was a teenager. When her mother joined her for family therapy sessions, certain missing pieces were described.

The mother began to point out that, while she insisted that she had never minded her husband's actions, for years he had chosen to spend the vast majority of his free time with his daughter. He would bathe her and tuck her into bed at night, often falling asleep there in her bed. The mother then pointed out that his bathing of the girl had continued into her teenage years, and that the girl (client) should not have permitted this. It became increasingly clear that part of the legacy of the father's untimely death was the mother's manifestly denied but repeatedly insinuated blaming of her daughter for his abrupt illness years ago. The mother spontaneously mentioned several times that she had never been bothered by the father's allotment of his time and attention. The daughter seemed to me to be unusually timid and deferential in her mother's presence. However eventually, and after great struggle, she pointed out that despite her mother's repeated spontaneous assertions that there had never been any competition or bad feelings between the two females, that she -- smiling tentatively at first as she said this -- thought that perhaps there were.

In subsequent individual sessions, this young woman told me that she'd realized why she was always thinking about men in leather jackets. If she were with such a tough man, maybe he'd beat her mother up. Parallels regarding her thoughts about myself and her father began to be explored. Eventually she told me, "I stay sick rather than let out my anger at my mother".

Interestingly, it should be noted that the occasion for these revealing family sessions was her mother's insistence that I fill out forms declaring her daughter to be mentally disabled, so that money could be made available to the daughter from a fund related to the deceased father. The daughter felt more ambivalent about this decision, particularly since being declared disabled would suggest a disqualification of her mental faculties and perspective. There also seemed to be a sense in which another legacy of the father's death would be the concretization of her identity as a "mental patient". But she alternated in saying that she deserved the money. Eventually the mother influenced her daughter to find a different therapist.

Another example will give a picture of "psychotic" communication in finer detail, with another "schizophrenic" client who'd been hospitalized numerous times. This middle aged man told me in his intake session that his previous therapist was a very pushy and provocative man, and described his own similar conflicts with his father. He pointedly declared any discussion of certain

other familial issues as being off limits. He next met privately with a psychiatrist to arrange medication. I was later informed that that physician had recommended an injectable major tranquilizer which the client rejected. The psychiatrist acceded reluctantly to the man's request for an oral (pill) form.

However, I didn't know of these things before the first therapy group the man attended, where he immediately remarked on the quietness and the laissez-faire manner in which I conducted the group. This was unlike the "pushy" therapist, he said, who would "make you talk, dragging things out of you, if necessary". He kept interrupting the otherwise relatively quiet group saying, "You're going to pull this out of me anyway, I just know you'll tear it out of me, so I might as well tell you". He then proceeded to tell me about strange occurrences within his brain. He asked if I knew what androgens were. I asked if he meant the hormone. He corrected me, explaining how androgens were when your brain was taken and made into a machine (note the possible play on the word 'androids'). This, he told me, was his basic problem: that his brain was being turned into a machine. He elaborated by referring to the movie The Stepford Wives. (That movie was based on the novel of the same name (Levin, 1972) in which a married woman, new to a suburban New England town, gradually discovers that each local housewife is being secretly replaced by a robotic version of herself which will be more servile to her husband. Also, on the day that the protagonist herself eventually succumbs to the forced replacement, she first tries to appeal to a psychiatrist, who instead gives her tranquilizers and suggests that she needs therapy.)

The psychiatrist with whom he had recently met joined the group during this lengthy and excited discourse by this man who was dominating the group with his loud and rambling embellishments of the above noted themes. Gradually, the psychiatrist suggested to the client, gently but indirectly, that perhaps he should have an increase in his medication. When it became clear that the physician was suggesting the medication increase, the man turned to me and asked what I thought. I told him that I saw the issue differently. I pointed out that he'd been talking about powerful doctors, about his expectation of having things torn out of him, and having his brain turned from something human into something machine-like, as well as The Stepford Wives imagery. If those were his concerns, perhaps he was saying that tranquilizers, or an increased dosage, weren't what he wanted.

Some weeks later, the same psychiatrist told me that a close relative of this man had written to him requesting that we: 1) insure that the client be declared disabled and get state financial support, and 2) not let him stop taking medications as he'd done in the past when he'd "gone off his rocker", and 3) give the man injectable major tranquilizers in spite of his objection. The psychiatrist told me that he had already written back, acknowledging the letter and generally agreeing with the relative, while pointing out that the client had declined injections. He gave me copies of both letters for filing.

When this man came in for the next group, I told him what I knew of the situation, told him that I hadn't read the letters, but that he was welcome to see them. He read them, smiled, and immediately began to protest that this was a misunderstanding -- that he agreed completely with his relative and the psychiatrist, and that he had always agreed to the injectable medication. He

preferred it, in fact. He later talked about how his only financial support came from some family members, and that he would just have to wait until they died to get an inheritance. Then he spoke at length about how his mind was being replaced by a machine, and how everything he saw, thought or heard was being broadcast to New Haven. I didn't see the connection until the end of the group when I found a state disability evaluation form in my mail box, sent to me by the man's relative, with a return address in New Haven. After the group, the man remained to receive an injection of major tranquilizers by syringe.

In the next session he attended, this man described a vignette in which he had been sitting, minding his own business and smoking a cigarette, when a person came up to him and threatened him with a knife. He said that the guy who threatened him must be crazy, and the only way to handle such a crazy person was to get out of there. I thought perhaps it was not an accident that he had mentioned his assailant's ethnic background (which was the same as that of the psychiatrist), and that he had spoken of being threatened with a sharp object.

Here is another, more longitudinal description of a therapy. This young woman had been hospitalized previously many times, often with different "psychotic" diagnoses. She spent her first individual session speaking of the fact that peoples' eyes changed. She asked me if I knew of time shifting, how people could come from the past into the future and vice versa. Primarily she spoke of her telepathic contact with a popular celebrity who had been her childhood lover and therapist. This celebrity often said demeaning things to her, but he had also been the best lover. He maintained contact with her now by putting voices into her head. She also told me that her mother was a famous novelist. That was not literally true, but I later learned that the author she named was known for her sexually explicit writings with incestuous overtones, and for some biographical controversy regarding the reality of her own incestuous experiences.

Over some months in therapy she seemed to hint indirectly at her fears about our relationship. As I would wonder out loud about the potential meaning of stories she told me, she would then often speak more directly of her fears that I didn't like her, was bored or angry, or didn't think she merited individual therapy sessions. Many times I felt the issue of my trustworthiness was being raised, particularly whether I would take responsibility for my contribution to some difficulty between us. For instance, once I returned to the clinic office to be told by a secretary that a relative of this woman had called long distance several times in my absence, and was again on the phone now asking to speak with me. I chose to take the call, explaining to the relative that I could say nothing about someone in therapy. I agreed to hear the relative out, with the understanding that I would repeat all that was said to the client later. The relative then criticized my attempts to help the client, telling me that I didn't realize how sick she was and how much more directive involvement she needed.

When I opened the next individual session by relaying this occurrence to the woman, and acknowledging the potential breach in confidentiality in my handling of the situation, she assured me that this was fine and that I could continue to handle such situations in the same way in the future. She then told a vignette about her boyfriend, whom she thought was unfaithful to her. She thought he might have given out the keys to their apartment to someone else. She also said that she

thought that their phone was tapped. I pointed out the potential parallel between her vignette and how I had started the session; that my handling of the phone call could be described as a breach or unfaithfulness in a relationship, or the violation of a trust involving a previously secure structure or private conversation. She said nothing at first, but then nodded her head vigorously. We discussed how to handle such situations in the future, with her choosing that I should not accept calls from anyone.

Not long after that, by chance I encountered this woman as we both were swimming in a public pool. I was particularly uncomfortable with this because of her ongoing references to her celebrity therapist/lover. In the following weeks I pointed out her indirect references to relationships in which boundaries were blurred, and in which people were potentially devious, sometimes with sexual overtones. I referred specifically to the swimming pool encounter, and I decided to reiterate the limited and specific nature of our work relationship together.

As our work continued, this woman increasingly hinted at sexual concerns. One afternoon, uncharacteristically, she telephoned me. She sounded very shaken and frightened as she told me that she was "beginning to remember things". She went on to detail how she had been molested as a child by that celebrity, or someone who looked like him. (I had previously noticed that there were two men about whom she would sometimes vacillate in recounting memories, saying it was "either him or someone who looked like him" -- the celebrity and her father.) She said that a cuddly stuffed animal toy had been used to violate her sexually. She calmed eventually as we talked, but I was still surprised later in the afternoon when she called me, quite emotionally composed, and told me that those things she had described hadn't happened. She said she had made them up.

At times this woman acceded to family members' requests for family sessions. Guidelines were established making clear that we would only meet at her discretion, and that only she could choose to reveal any material from the individual sessions. With her mother present she began to use imagery of sexual secrets, referring to events that had occurred previously. Eventually, since it appeared that the mother was hinting at her discomfort with the daughter's allusions to sexuality , the daughter seemed to more directly request to discuss sexual incidents that may have occurred when she was a child. The mother looked genuinely chagrined and uncomfortable, but eventually spoke of how school counselors had pointed to possible sexual imagery in pictures her daughter had drawn as a girl. The mother then compellingly spoke at length about her own very rigid upbringing, and the supreme discomfort she felt in discussing sexual matters. She described her sense of being overwhelmed, unprepared and unable to deal with them as a mother years ago. She very tentatively agreed that perhaps there had been sexual occurrences or preoccupations that had troubled her daughter since childhood. The daughter seemed very attuned to her mother's hints at how frightening and threatening she found these topics to be. I was reminded of the times my client had told me that she received government money as a pay-off for her silence, and that she feared she would be killed if she discussed certain topics.

Some weeks later I was notified that this woman had been brought to the emergency room by her family members, who were trying to convince her to be admitted to an inpatient unit. It was the day of her usual session, so I offered for her to keep that appointment if she chose to. She

showed up with her family. Family members started out by telling her that she wasn't rational right now, and that she should recognize that she was sick, and that her "schizophrenia" was probably going into phase. She was quiet at first. Eventually she interrupted, yelling about a plot, a conspiracy with the CIA and the FBI involved, and that everyone seemed to be brainwashed and hypnotized. She told me that she thought I was brainwashed too. She then started to hint at sexual intrigues or secrets. When I got her permission to comment on the "plot" and "brainwashed" imagery and the reference to sexual intrigues, I connected these images with the discussion in the last family session. She began to calm a bit. I ended by asking what had happened with that discussion since the last family session. She then yelled, "That's just it! No one will talk to me about it!"

During this session, the family eventually confirmed that when the patient was a girl, some adult sexual infidelities had led to a gory death in the family's presence. Actual death threats at that time, as well as the fear that the courts might still now intervene if other illegalities and sexual misconduct were revealed, made people quite hesitant to speak openly. However, it was eventually revealed that the client was not the only sibling who had confirmed that ongoing secret sexual abuse of children by adults had taken place in the home. At the end of the session, one family member who had been quite verbally abusive and threatening toward me on some occasions, sincerely asked me if I thought that the family might be undermining the therapy.

Here are a few other highly condensed descriptions of what I saw as the central imagery that developed and was explicated in therapy with other "schizophrenic" patients:

A woman felt that for years she had lived within a conspiracy against her in which people wanted her to be sick or die. She wondered if the conspirators wanted her to drink bleach. She was unsure if she'd ever been made to drink urine or to eat worms, and she had a vision of having a group of men sticking a bird down her throat. More than once, as I would sit with my hands together, supporting my head, and with my fingers under my nose, she would exclaim, "Dr. Shulman, why are you jamming your penis up my vagina?". Eventually she began to have memories of having been raped by a group of men, in one instance, and revealed other chaotic and frightening aspects of her sexual history both within and without her family .

A woman who was usually silent in group therapy was provoked and taunted by a male group member of another ethnic group. She began to scream at him that she was a full blooded Sioux Indian (not factually true) and told him that she would take a tomahawk to him and turn him into a squaw, and then dance around inside his tepee and see how he liked it. At a later group she revealed a childhood history of racially tinged rapes.

A teenage girl who dressed revealingly and applied unusually large amounts of makeup spoke very little, but sometimes mentioned visions of snakes crawling into her bedroom at night. Eventually she told of ongoing incest which was corroborated by others.

A woman nervously asked to have her young daughter accompany her to her first appointment with a male therapist. She then spoke of how she had tried to keep Martians out of her

room when they hovered by the window, but that they intruded in spite of her closing the window and blinds, and they abducted her. She hesitated, looking at her daughter, but then explained how her captors "examined" her and hurt her in exploring her genital region. She then had her daughter leave the room as we began to explore the possible connections with actual sexual assaults, which she then began to say she had sustained. She also elaborated on a recurring image she had had of male figures who come towards her menacingly. She described how she cries out,
but no one hears what she says.

Conclusion

Other writers have documented the benefits of similar therapeutic explorations. In The severed soul, analyst Herbert Strean (Strean & Freeman, 1990) gives an extended case study to demonstrate the amenability of "psychotic" or "schizophrenic" primary process verbalizations to traditional psychoanalytic exploration (see also Strean & Freeman, 1988). Peter Breggin's Toxic psychiatry (1991) gives other similar case examples. In their book Psychotherapy of schizophrenia: The treatment of choice (1981), Karon and VandenBos illustrate through case materials how exploration of such verbalizations provides clues as to their unconscious expression of reactions to trauma and conflict. Others provide similar examples of explorations of metaphors in psychoanalysis or psychotherapy with "schizophrenics" (e.g. Boyer & Giovacchini, 1980; Langs & Searles, 1980; Ferreira, 1960; Karon, 1992; Searles, 1965; Will, 1961). Modrow (1992) recounts in autobiographical detail the compounded tensions in his family and early life which led to his own unusual behaviors and fantasy, earning him the diagnosis "schizophrenic".

Spence (1987) criticizes the tendency toward "narrative smoothing" in most condensed case presentations. I believe his arguments raise important issues. Clearly, the clinical situations I presented here have emphasized certain of the symbolic highlights or recurrent themes in each therapy. The reader sees these events only through my eyes, in condensed form and with hindsight. However, I emphasize that I am not urging clinicians to accept my viewpoint on the subject of metaphorical communication in "psychotic symptoms" solely on the basis of these descriptions. Instead, I urge clinicians to listen to people with such "symptoms" and "diagnoses" in therapy, and to judge my perspective based on their own subsequent experience. Certainly I am trying to be compelling here in recreating the stories of these people's lives. But that is because I have been compelled by these camouflaged communications, which repeatedly seemed to be hinting at traumatic and deeply upsetting experiences. Such seemingly formative and traumatic experiences have come into sharper focus and have regularly been confirmed in reality over the course of discussion in therapy. The strongest argument I can provide that does not depend heavily on the inevitable human appeal, charm and drama of a case description, is to encourage clinicians to try such an exploratory approach in therapy themselves.

I urge clinicians to avoid being blinded or prejudiced by predominant theoretical models which suggest that the temporary incomprehensibility of someone's actions or speech can be resolved by the affixing of labels such as "delusions", "hallucinations", "thought disorders" or "psychoses"; as if those labels explained to us that these phenomena should be deemed (or

dismissed as) narratively or symbolically invalid, inexpressive or ultimately incomprehensible. Those models then suggest to clinicians that they should take such clinical phenomena as "symptoms" of a "diseased mind", or evidence of an incompetent person. The "patient" is then seen as someone who should be "helped" by a "supportive", "directive" or semi-paternal or authoritarian relationship. In other words, such temporarily incomprehensible words and actions are taken as a cue or justification for ending therapeutic exploration between two consenting and competent autonomous adults, and for beginning a relationship which is invalidating for the "patient", and which is symbiotically dominant/submissive. Szasz (1976) describes the relationship that typically develops when "schizophrenia" is "treated" as a "disease".

I will conclude by mentioning some writers who offer corollary support for the perspective I have presented. Watzlawick, Beavin and Jackson (1967) state that "psychiatric symptoms" of "schizophrenia", viewed from the standpoint of communication studies, suggest that these symptoms may be viewed as a "reaction to an absurd or untenable communicational context (a reaction that follows, and therefore perpetuates, the rules of such a context)..." (p. 47). My repeated observations (such as the cases cited) suggest to me that their viewpoint is relevant and accurate, and contributes to understanding each individual therapeutic puzzle presented to us in clinical practice. Their view also suggests just how powerful it can be to break that cycle of problematic communication.

Rosenberg's (1984) analysis of "psychosis" emphasizes:

> These symptoms of schizophrenia are enormously varied. Some involve thought, some affect, some behavior. There is no obvious logical connection among them. Although they are apt to be characterized by distress and disability, the chief feature that they have in common, we believe, is that naive external observers are unable to understand the response in terms of the actor's frame of reference, intentions, motives, or desires, in ways that fit the observer's theories about the wellsprings of human action. When this occurs, the behavior is viewed as insane. (p. 293)

The author underlines that, for professionals and laymen, the determination of "sanity" or "psychosis" is based on the ability of the observer to understand or "take" the role of the other (the patient), with one exception. People are not judged to be insane "when the observer attributes the failure to take the role of the other to his or her own limitations" (p. 289).

Only after considerable clinical experience with case examples such as those cited did I read Ferenczi's (1932/1949) "Confusion of Tongues..." paper. Although such aspects of psychoanalysis were not commonly discussed then, Ferenczi felt that his patients were often critical of him, in a way that was expressed in somewhat veiled communication. When he began to respond to those criticisms, with some acknowledgement of the element of accuracy in their descriptions of his inevitable faults, flaws or mistakes, he found that people were more likely to begin to reveal to him formative traumatic events and patterns in their childhoods. He felt that it was a unique and moving therapeutic event for such people to have a powerful figure acknowledge responsibility for their hurtful contribution to their difficulties. It was on the basis of numerous revelations of trauma

by patients in therapy that Ferenczi urged Freud to reconsider the change of position he had taken, in which Freud abandoned his original thesis that emotional difficulties tend to stem from actual trauma (sexual and otherwise), and not from unconscious fantasies. (We have already seen how Lidz (1973) came to a similar viewpoint.)

It is worth repeating the factors that Ferenczi believed facilitated revelations of both trauma and complicated emotional binds in therapeutic work. He came to focus on camouflaged and ambivalent communication that often suggested a criticism of the therapist. He found that it was a powerful therapeutic intervention to acknowledge the potential relevance of that communication within the therapy, and with special regard to actual actions and comments of the therapist that are, to at least some extent, accurately perceived as injurious or hurtful. For the "psychotic" patient, this also entails acknowledgement of the "meaning in their madness", the relevance of their primary process associations, particularly in the context of the therapeutic situation.

In this regard I am reminded of two quotes. Szasz (1976) said: "Actually, often the only thing 'wrong' (as it were) with the so-called schizophrenic is that he speaks in metaphors unacceptable to his audience, in particular to his psychiatrist" (p. 23). Twenty years previous to that, Bateson, Jackson, Haley and Weakland (1956) had noted, "the peculiarity of the schizophrenic is not that he uses metaphors, but that he uses unlabeled metaphors" (p. 253). Later they pointed out: "The convenient thing about a metaphor is that it leaves it up to the therapist... to see an accusation in the statement if he chooses, or to ignore it if he chooses" (p. 255).

I urge clinicians to consider doing traditional, consensual, exploratory therapy, that includes reasonable attention and respect for therapeutic frame and boundaries, with the people we call "schizophrenic". Consider the possibility that a metaphorical (or unconscious) commentary is being provided, just as you might listen for it in therapy with others. Let it be your guide. I believe you will be convinced of the poetic relevance of what is being said.

It is possible to do a voluntary, exploratory, uncovering or psychodynamically informed therapy with the people we call "psychotic" or "schizophrenic" that is not so different from therapy with other people. Although the metaphors that are explored at first may seem relatively more unusual, bizarre or somewhat alien; to borrow a phrase from Harry Stack Sullivan, the therapy and the life stories that emerge, nevertheless will be "more human than otherwise".

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