Brief Treatment of Psychosis from a Developmentally Informed Psychoanalytic Perspective

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6.1 Introduction

This chapter considers a developmentally informed psychoanalytic approach to brief encounters with individuals with psychosis. Such an approach in no way suggests that it is useful to employ classical psychoanalytic practice with a patient lying down on a couch and free associating. Rather, the approach put forth here is derived from psychoanalytic work with children in which patients present material in whatever way they are able, and it is the therapist's job to help them articulate the material, organize it, make meaning from it, and, from this, help them get themselves back on track developmentally (Freud 1963). This approach nurtures the process of development itself and can be used with all children, adolescents, and adults, including ones who are overwhelmed with a psychotic process, as this chapter will elucidate.

For the many readers of this book who might be expecting a prescription for how to conduct a therapy using the psychoanalytic approach that is described here, this chapter does not prescribe any such procedures. Rather, it elucidates a stance taken by the therapist. This stance is characterized by a kind of listening and being open to whatever material is presented by the patient. As such, it does not require anything from the patient other than to produce spontaneous material. For example, from this perspective, paranoia is spontaneous material to be understood and not a barrier to the work. Freud demonstrated this stance in 1905 (Freud 1905) when he discussed transference, which is a form of mistaken reality, and it has been elaborated in the psychoanalytic literature hundreds of times since then. Even catatonia is a spontaneous production that can be worked with and understood.

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Safety, of course, is a prerequisite to doing any work with a patient. Among other reasons, the therapist not being under threat allows the therapist to think clearly about the patient. But other than safety, there are no prerequisites and no patient attributes that would be a barrier to this approach. There are, however, two important barriers to consider in this work: those within the therapist and those in the context of the patient's environment. Both of these barriers will be discussed further below.

The chapter begins with clarification of the chapter title and continues by organizing these terms in relation to one another. Two examples subsequently will demonstrate both how to understand psychosis from this perspective and where and when one might intervene. These examples will highlight the special role of anxiety, attachment, and disorganization and bring in to bold relief the usefulness of tracking and making use of these phenomena. The challenge for the therapist using this developmentally informed psychoanalytic approach is to accept the patient however they present, use this as the starting point, and begin the therapeutic process by helping the patient organize themselves around what the patient's chaos is.

6.2 A Developmentally Informed Psychoanalytic Perspective

The term "psychoanalytic" has been used in many different ways throughout the literature. Its use here in this chapter is meant to be in the broadest sense. In that sense, "psychoanalytic" refers to the study of thoughts, ideas, feelings, and experiences (experiences in the broadest context including bodily experiences, here and now experiences, as well as experiences held in memory), with the understanding that there is much more to the thoughts, ideas, feelings, and experiences than is immediately apparent and available. That is, any thought or feeling that is presented is accompanied by a nexus of other thoughts, feelings, memories, and experiences that are not in awareness. Another way to describe this is "depth psychology."

"Development" is meant to refer to both the process and the stages of maturation. Infants are born with certain functional capacities psychologically, including cognition, emotion, self-regulation, and ability to relate to others and to organize oneself and one's thoughts. These capacities grow over time and depend on many factors including the constitutional factors and the encounters that the infant has with the world. With these forces at play, the personality takes on its own unique patterns and evolves. So, "development" as used in this chapter refers to the expected maturation of the functional capacities and also refers to the unique evolution of the individual personality.

Development is pushed forward when the person (infant or adult) encounters a challenge for which they are not presently equipped to address. This "developmental challenge" motivates the person to evolve to meet the challenge. When a person encounters a developmental challenge and develops new capacities in order to adequately address this challenge, then we recognize that there has been an evolution, a maturation, or development of the individual. If, however, a person is not prepared

to meet this developmental challenge, then we begin to see a breakdown of the personality. For example, think of the development of organizational and problem solving capacities such as putting together a puzzle. The normal progression is to put together a 2-piece puzzle, then a 5-piece puzzle, and then a 15-piece puzzle. Each challenge is an incremental step and requires the capacities developed up to that point plus the additional challenge. However if a child was not given the opportunity to put puzzles together, or a puzzle demands far more than the child has developed, then the child will likely not succeed. So, for example, if a child is exposed to sexual stimulation far beyond their developmental level, this will create problems. If the child is 5 years old, that will create one possible set of problems. If the child is 15 years old and has not experienced normal developmental experimentation, that will create a different set of problems. This latter circumstance may occur due to the environment being too restrictive; it may be that the child is too anxious to experiment for constitutional reasons, or it may be that the child has been sensitized due to early overexposure/overstimulation, again leaving the child too anxious to proceed.

6.3 Psychoanalytically Informed Developmental Conceptualization of Psychosis

Using the terms mentioned above, consider a conceptual model of mental and behavioral phenomena that is different than thinking about disease or illness. Consider the possibility that symptoms are a manifestation of unmet developmental challenges. For example, a developmental challenge for adolescents is to operate within an adult body. Adolescence is considered here because psychosis more often than not presents in the context of adolescence. The adult body presents challenges for boys to tolerate and manage the increased feelings of aggression and sexual drive created by increased levels of testosterone. Likewise, girls face challenges with increased estrogen and progesterone, with increased drive to relate to others and be comfortable with their own boundaries. Another challenge for adolescents of both genders is to manage their new adult sexual body itself.

Yet another overlapping developmental challenge for adolescents to manage is the increased independence that comes with adult capacities. There are many implications here, one of which is that a child's mind must take on organizational capacities that the newly minted adult's body now demands. These organizational capacities must take on new social and interpersonal demands, as well as make meanings of internal experiences, feelings, thoughts, fantasies, impulses, etc.

In addition, these demands must be taken on with much less support and oversight from parents (Erikson 1956). This is likely why psychosis most commonly presents at this stage of life – parents are not there to stop the free fall of degrading ego functions that can occur under the pressure of development (this is described more below) (Browning 2011). These are tall demands, and if the child's mind has not been equipped and prepared for these challenges, but solutions to these challenges are demanded, as one cannot escape one's body, then there are unmet

developmental challenges of epic proportion. The child is between the devil and the deep blue sea.

There are many possible solutions to this epic challenge, depending on the various conditions including those of the preadolescent development. But if no adequate solutions are reached, anxiety will escalate to the point of overwhelming the individual's psyche including the ego apparatus, and thus disorganization of thought processes ensue. It is not uncommon to see short episodes of disorganized thoughts in adolescents, which resolve when solutions are found. However, if the challenge continues to go unanswered, disordered thought takes over the various functions of the mind more and more. At that point, in an effort for the person to preserve their psychological integrity, they will reach for models of reality that do not match reality itself, such as those seen with delusions and hallucinations. This is a psychoanalytically informed developmental conceptualization of psychosis (Fallon 2014). It also fits in with the stress-vulnerability model of schizophrenia proposed by Zubin and Spring (1997) in which the challenging event is the developmental challenge from within.

Let us approach this concept again anew, this time from another direction. Let us consider that the mind develops and holds a map or model of the reality that the person has experienced. The mind uses this model to navigate and make decisions as to how to proceed, considering what it knows of the outcomes and consequences according to that model. Some of this model may be articulated, but much of it will be contained in bodily experiences and will be detected only by the actions and inactions taken or not by the individual. Psychoanalytic work aims at helping to articulate and give meaning to the model and the actions/inactions.

Development can be conceptualized as a progressive evolution of this model of reality. The first model of reality for the infant is "I feel bad; I cry; I feel better." This model is soon displaced by another that includes "someone out there who does something that makes me feel better." These preliminary models are simple and in the beginning lean heavily on built-in responses such as crying in response to overstimulation. Through successive evolutions of this model of reality that are more and more complex, the child is able to take into account more and more properties and subtleties of reality and themselves, becoming acquainted with more and more parts of themselves and the world outside themselves. The evolution of these models of reality aims to create a model that more closely predicts real outcomes. There are moments when the individual encounters information or events which can't be accounted for by these models. The distress of the unmet needs in addition to a sense of not knowing what is going on (something is happening for which the model of realty is not reflecting what just happened) forces the individual to modify the model to one that better accounts for (predicts) outcomes. This is what characterizes increased maturity. With each progressive developmental challenge, the individual acknowledges that the model they have of reality is inadequate, deconstructs that model, and then formulates a new one that takes into account the new problem and a new solution.

Sometimes, however, conflicting feelings or beliefs are held and the individual has a difficult time resolving these conflicts. These conflicts then interfere with

deriving a new, higher fidelity model of reality. These more difficult to resolve conflicts usually involve core or foundational aspects of the model of reality. And yet development must proceed as dictated by biology, especially, for example, in adolescence.

6.4 The Case of Jay

A clinical example will be useful to illustrate the concepts presented thus far. Jay, a 19-year-old man, presented after attempting to kill himself, knowing that he would be reborn into a new, more perfect world where men were women and women were men. The idea of a more perfect world was a manic defense to an underlying despair in which he felt he could not go on in his world. One of the first statements that he made as he began his therapy was that it would be a lot easier if he was homosexual. His next thought was a question – was he homosexual? From there, the details of the material he presented for the next 6 months were a confusing chaos of words, even as his movements were stiff and uncoordinated and his speech was halting and fragmented.

After 3 years of four to five times per week listening and trying to sort out this chaos, during which a minimal amount of medication was used, he came to an understanding of his unresolvable adolescent developmental challenges. During the work, when the chaos in his mind left him with anxiety that he could not bear, he requested and was given up to 1 mg per day of risperidone which he reported as turning down the volume of the anxiety, allowing him to think more clearly, albeit more slowly. He was begun on this medication in the hospital at a dose of 5 mg per day after his suicide attempt but discontinued it as soon as he was discharged because it made him feel terrible. After a month of analytic work, he complained of the chaos and anxiety and agreed to try one-quarter milligram at bedtime. After a few days, he noted that it helped a bit and wanted to try more. The dosage was increased to 0.5 mg/day, then 1 mg/day, and then 1.5 mg/day. At that point, he said he felt like his thinking was walking in thick deep mud and that evil threatened to overtake him. The risperidone was reduced to 1 mg/day and this feeling resolved. He took the risperidone intermittently under supervision, and by year 2 of therapy, he no longer needed the medication.

The psychoanalysis consisted of the therapist listening to him as he attempted to express and then organize his thoughts and ideas. Even 4 months into therapy, the therapist could not articulate much about what was being expressed. However, the act of listening and attempting to follow and make sense of Jay's productions was deeply therapeutic and even lifesaving as demonstrated by an event that occurred in the fifth month of therapy. Up to that point, the psychoanalyst listened and noticed that Jay gradually became less stiff. He completed more and more of the sentences that he would begin and there would be less vacant pauses. Later, Jay would indicate that during those vacant pauses, he was attending to his hallucinations and delusions.

His family reported that he appeared more organized and even began to participate in family activities such as meals and was sleeping regularly and attending to his hygiene. The psychoanalyst planned to be away for 3 days, working with Jay

and his family for 2 weeks prior to the absence. It was arranged that Jay and his analyst would speak on the phone at an appointed time every day. On the second day of the analyst's absence, Jay again attempted suicide and was again admitted to the hospital. On the analyst's return the next day, Jay was discharged. When the analyst asked what happened, Jay indicated that when he could not sit with the analyst and work to put his thoughts together, everything again became chaos and he was left to figure it out for himself.

After some time, the therapist began to notice that when Jay talked about certain topics such as his mother, his father, or sexuality, he would become more disorganized in his thoughts, speech, and movements and have more vacant pauses. After a time, the therapist would call Jay's attention to this sequence, and after the therapist repeatedly called Jay's attention to this sequence, Jay himself began to notice it. Soon fragments of associations began to arise, for example, in association with thinking about his mother, he would mention a certain type of tree. Again, when the therapist noted this and asked about this tree, after some thought, Jay remembered that it was a tree under which he took comfort as a child. However, sometime during his childhood, his parents cut down this tree which left him feeling abandoned. If the therapist missed an opportunity to make meaning of something which Jay felt overly anxious about, Jay would begin to experience psychotic symptoms. However, if Jay became aware of his own anxiety and then could make meaning of the anxiety himself, he would experience increased clarity.

Gradually over the 3 years of psychoanalysis, Jay constructed a narrative of his life that put his psychosis and his suicide attempts into perspective. Early in his childhood, Jay was raised by his father whom he deeply admired and with whom he heavily identified. His mother was preoccupied with her own developmental challenges and unable to attend to him throughout his life. By the time Jay was 8 years old, his father had become depressed and withdrawn, leaving him without any substantial parental support. The father's depression was due to his frustrated homosexuality, as he posed as a heterosexual husband. In Jay's early adolescence, the father left the family home and resumed the gay lifestyle that he had had prior to his marriage. In his adolescence at age 17, after Jay had experienced his first intimate sexual relationship, he became psychotic. The psychosis began to resolve in the context of therapy when he began to recognize the conflict between his early identification with his homosexual father and his own newly found adolescent heterosexual desires. At one point in the therapy, he even noticed that when he found himself exhibiting his father's feminine mannerisms, he would begin hallucinating.

Prior to therapy, Jay had not been able to resolve this conflict at the bodily experience level. This unresolved developmental challenge led to a depression and psychosis. In the context of this depression and psychosis, he came to a solution that did not match reality – killing himself and being reborn into a world where men were women and women were men.

If one considers the psychoanalytic developmental model described above, it makes sense that as Jay was presenting in his psychotic state, there was much going on below the level of awareness, even as he was revealing the deep underlying conflicts in plain sight – it would be so much simpler if he were a homosexual like his

father. Becoming aware, articulating, and giving meaning to these conflicts then allowed him and the analyst to intervene with reason and alternative meanings, placing the conflict in a new context. This new context changed the questions and what was previously experienced as a conflict was now experienced as simply his history.

Jay's intensive and prolonged therapy was certainly not brief, but it demonstrates that even on presentation of the psychosis, there is meaning, most of the time in plain sight, and still there is a puzzle yet to be understood.

6.5 The Case of Bernard

Let us now consider an example of a brief encounter with psychosis and how a psychoanalytic developmental model might be useful in the moment. Bernard, a 28-year-old African-American man, presented to a psychiatric emergency room very anxious, paranoid, and fearful that the devil was pursuing him. As the attending physician encountered him, sat, and talked with him for a few minutes, Bernard seemed reassured that he was now in a safe place. The resident physician then stepped in to complete a full evaluation in order to consider an appropriate disposition. As the resident approached Bernard, Bernard began screaming that the devil was among us and had come to get him. Bernard proceeded to barricade himself in a corner of the room, preparing to be attacked.

After 20 min of chaos, Bernard was placed in physical restraints. The attending physician again approached him as he had in the beginning and again Bernard gradually calmed. Agreeing that he felt safe now as he had felt safe before, the attending physician asked him what had changed and when. He said the devil had come for him and the attending physician wondered if he was referring to the resident physician that had approached him. Bernard now became more anxious. Again, the attending physician calmed him and was then able to ask him how he knew that the resident physician was the devil. "Because he's black" was the answer. The resident physician was from Africa, and indeed he was very dark skinned as was Bernard himself. The attending physician felt a momentary sense of confusion and disorientation as he heard himself say, "but you're black, too." Suddenly Bernard was saying, "That's it. That's it." With that, there was a lessening of anxiety and expression of psychotic thought. Further history revealed that Bernard had been living in a shelter that was cramped and overcrowded. He felt dependent on the shelter for food and physical protection and yet became angry and began to feel murderous rage toward the shelter staff. That was when he got the idea that the devil was after him. It is easy to imagine that he projected his murderous rage onto an imaginary devil that was in his own image and included being black. It is also likely that this murderous rage originated earlier in his life and resonated with his present situation in the shelter. By the time this history had been obtained and created into a meaningful narrative shared by both the evaluator and Bernard, Bernard appeared comfortable and happy and prior to being admitted was last seen enjoying a hospital cafeteria bagged lunch, which was not that good.

As in the case of Jay, Bernard's initial symptoms were manifestations of unconscious processes. Helping Bernard to articulate and make meaning of his present situation, as well as helping him to explore the possible origins of his symptoms in the context of his present life, was useful. Useful longer term work would be to explore the origins of his symptoms in the context of his development. As was suggested in the case of Jay, longer term work with Bernard would be slow and would likely need to be intensive and very supportive. Nonetheless, even in brief encounters, keeping in mind this psychoanalytic developmental perspective can help guide the initial evaluation. It will then be important to pass on information gathered during this initial evaluation, even as the disordered thoughts are unintelligible loose pieces to a yet-to-be-put-together puzzle. Also such psychoanalytically informed developmental models provide an in-depth understanding of the client's symptoms and dysfunctions, and this deeper understanding on the part of the therapist may serve to make better decisions with regard to the patient's reality and can pave the way to deliver better therapeutic care to individuals with psychosis.

6.6 Brief Therapy

Since this book is focused on brief interventions with psychotic individuals, it is pertinent to comment on how brief is brief. The model used for the psychiatric emergency service in which Bernard was seen, operated in the context of a public mental health community system of care. In that context, patients were not triaged and disposed of, but rather were held continuously in a nexus of services and agencies. If a patient was being served in one agency such as the psychiatric emergency room, as long as the patient needed that service, there was no rush to move that person to another setting. The service that was provided in the psychiatric emergency room was a place where acute behavioral and mental health crisis were contained, and data gathered, making contact with as many entities as could be garnered to create the most robust picture of the person who presents in crisis. This meshed well with the developmentally informed psychoanalytic model in which insight came in a moment of understanding. A psychoanalytic moment might be just a moment in time as in an acute traumatic moment or the aha moment of insight or a moment that could last a lifetime as in the traumatic moment that is relived again and again or a relived moment that sustains a person through a holocaust. In Bernard's case, the attending physician spent perhaps 25 min with him in total during this evaluation. Bernard's moment was in the terror that he experienced. Exploring that moment led to the understanding that his moment of terror was also his moment of rage at those around him, who were supposed to be caring for him. The aha moment for the attending physician and then for Bernard came when the lived experience was also lived/shared with the attending physician, and together they made meaning of his fear and rage. The process of an evaluation, just as the process of a meditation, cannot be hurried, if one is really going to move the process forward. As daunting as it may seem, to evaluate crises, especially psychotic crises, a big advantage in the setting of

psychiatric crises such as one sees in psychiatric emergency rooms is that it is quite common to see a blatant revealing of underlying unconscious conflicts. The difficulty is in making meaning of these psychotic symptoms. In psychoanalytic jargon, it is id material without any ego to help us understand or interpret.

Habib Davanloo (1995) articulated a model of short-term (1 year) psychoanalytic psychotherapy called the intensive short-term dynamic psychotherapy (ISTDP). In his model, Davanloo does an initial interview in which he methodically strips away ego defenses, allowing him to "stroll through the unconscious." In the case of psychosis, those ego defenses are already stripped away, allowing a stroll through the unconscious without any of the preliminary work.

It is not recommended that one induce psychotic states in order to examine unconscious processes. It is also not recommended to attempt to externally contain the feelings and expressions of the psychosis, although it is also important to be sure that physical safety is maintained at all times. Efforts to contain the feelings will be experienced by the patient as people not wanting to hear how they are feeling or what they have to say, or feel rejected, or that their feelings are dangerous and must be suppressed. These efforts to contain the feelings may be made by therapists and staff to avoid making contact with the patient's chaos. This phenomenon will be addressed below.

On the other hand, as in the case of Jay, when the therapist comes to know the patient, attending to what stimuli leads the patient to become more disorganized provides clues as to the underlying conflicts. In that case, focused interventions to provide the patient with a modicum of structure and organization will result in a lessening of psychosis. In the acute setting, as in the case of Bernard, maintaining physical safety and then a review of the events and a cooperative exploration by patient and therapist of what is going on in the patient's mind frequently leads to a lessening of anxiety, intrapsychic chaos, and psychosis.

A note here is that none of this work can be done unless the therapist is mindful of his environment and a sense of safety. If the therapist is not in that state, then this work cannot be done. Trainees should be instructed from the beginning and repeatedly that if they have any sense of insecurity, especially in working with psychotic patients, they should not be in that place, should immediately get up without explanation, and leave the room for a place in which they feel safe.

6.7 The Role of Anxiety, Attachment, and Disorganization in Psychosis

In thinking about developmental challenges and the evolution (maturation) of a person's model of reality, anxiety, attachment, and disorganization have key roles. These processes become particularly important when thinking about psychosis as a maturation process gone awry and especially if considering assisting with getting this developmental process back on track.

Anxiety, from a psychoanalytic perspective, is an internal signal for danger (Freud 1923; Gray 2005). When this signal is at a tolerable level, it motivates the person to address the danger. However, when it moves beyond tolerable limits, the signal is

distorted, like an overpowered loudspeaker. Beyond this level, the signal becomes psychically painful and interferes with cognitive and ego capacities, creating disordered thought as evidenced by disorganization. In the context of a developmental challenge and the disorganization that precedes the new model of reality, anxiety is very high, degrading cognitive and ego capacities. Degraded cognitive and ego capacities in the form of disordered thought then create a sense of helplessness which creates more anxiety, which leads to more disordered thought. And so it goes round and round, spiraling down. In this feedback cycle continues, eventually there will be complete collapse of the ego. This is when thought disorder becomes psychosis.

When there is an attachment and a trust with another, that other, in this case the therapist, if effective, will dampen the destructive feedback of anxiety and disordered thought. The attachment or bond being talked about here is not specifically the attachment that occurs between mother and child (although that kind of attachment would be included in the definition). What is meant is something broader – the sense that another person, the therapist in this case, is there, aware of the patient's state, and the patient is trusting that if need be, the therapist will lend their ego and cognitive functions just enough to create a nidus of organization, but not so much that it overwhelms the patient who will be vulnerable to being overwhelmed. What fosters this attachment will be a sense of being understood.

In the face of psychosis, it is difficult to know how to be supportive and allow the patient to feel understood in the midst of such chaos if one just listens to the content, which many times does not make sense or is contrary to what we know of how reality works. This is where monitoring anxiety and disorganization is key, as they will rise and fall with internal disordered thought. Most therapists are attuned to monitoring anxiety. However, with psychotic individuals, it is difficult to monitor anxiety since the anxiety is overwhelming and not tolerated. Here anxiety is usually hidden among the myriad of defenses and the chaos of psychosis.

Although most clinicians are not attuned to disorganization, in a psychotic individual, disorganization appears everywhere and can be monitored in every facet of the patient's functioning including qualities of speech, movement, generated thoughts or sudden disruptions in continuity of thought, verbal productions, and actions. Attending to and monitoring this disorganization can be cultivated. The most difficult part of training this attunement is tolerating the internal experience of chaos. This is discussed more below.

Allowing the patient to express themselves, even as the material is disorganized, and thinking with the patient about that material as much as the patient can tolerate will foster a lessening of disorganization, and hence there will be a lessening of disordered thought. This will then allow more underlying disorganized and conflictual material to surface. When this underlying conflictual material begins to surface, disorganization will again increase. This was seen, for example, in the case of Jay when he noticed his feminine mannerisms and began to have hallucinations. This observation is done using what Paul Gray refers to as close process monitoring (Gray 2005). When there is an increase in disorganization, and especially when this begins to degrade the ego capacities and move toward that downward spiral described above, this is the point at which the therapist needs to lend organizing ego capacities to the patient.

The aim here is to provide some small interpretation that brings a new meaning that the patient can accept regarding the conflict. For example, in the case of Jay, he became more disorganized in the session and began to hallucinate after he noticed that his movements mimicked his father's mannerisms. When the therapist saw this increased disorganization, he said, "You notice that you are hearing voices now and a moment ago you were noticing your mannerisms that remind you of your father. I wonder what the connection might be." If there is a lessening of disorganization, then you have got it close enough. However, if the disorganization worsens, the intervention was either too much, too little (not very likely), or wrong. In any case, if the disorganization worsens after your intervention, you call the patient's attention to your intervention, noting that what you said does not seem to be correct and empathizing with the patient that it is painful when one is not understood. Then see if you can clarify with the patient what was not correct.

The result of persistent close process monitoring is a sense the patient has of being understood. Here a quick clinical vignette will illustrate.

6.8 The Case of Terry

Terry, a 14-year-old child in the autistic spectrum, had been admitted to a psychiatric inpatient unit in a psychotic state. For his entire 3-month stay, the therapist met with him almost daily, listening, providing close process monitoring, and organizing support when needed. For example, Terry began a session talking about school, saying it was going well for him and he was ready to go home. When asked what was going well, he pulled out a textbook, opened to page 279, and pointed to the page number. After 15 minutes of wondering about what Terry was trying to convey, the therapist noted the sequence as just stated above and wondered if Terry was uncomfortable with the specific question of what was going well. Terry nodded yes. The therapist suggested that maybe Terry felt some pressure about school. Terry again nodded yes. The therapist then followed up with the question: What was in Terry's mind when he decided to reach for the textbook? Terry responded that he really wanted to play a game of catch rather than do schoolwork. Terry and the therapist then proceeded to have a lively game of catch which, as Terry said, made him feel like he was communing with the therapist. As they played catch, Terry began to talk about his inner experiences.

As the work continued over the next few months, Terry's overt psychotic state subsided, although there were still many aspects of his state that had not been addressed and much of the source of the psychotic material was still not understood by his therapist or anyone else. Despite the remaining questions, as discharge drew near, Terry asked his therapist if the therapist would talk with his parents.

> What is it that you would like me to talk to them about?
> Tell them about me. You know about me. Just like when we played catch, tell them so they can understand too and they can help me like you have. This example illustrates the importance of feeling understood and allowed Terry to explore his chaos even in the face of not knowing.

6.9 Barriers to a Psychoanalytic Developmental Approach

6.9.1 Barriers Related to the Therapist

As simple as this approach would seem, there has been little written about it over the past 50 years. Prior to that, there were a number of authors who wrote about psychoanalytic work with psychotic individuals (Arieti 1966; Gottschalk et al. 1988; Searles 1961, 1976). Recently, there has been a resurgence of interest (Garrett 2012; Knafo 2012; Kocan 2012; Lotterman 2011; Marcus 2012; Slevin and Marcus 2011). One might wish that with the advent of newer medications, a psychoanalytic approach might be antiquated. However, recent data continues to show poor outcome for psychosis. So why would a simple and useful psychoanalytic development approach to psychosis be ignored? The difficulty may be found in the therapist's experience when doing this work. Using the close process monitoring as described above, one must use empathic capacities and in this way comes into intimate contact with the psychotic state of the patient.

Development is occurring in all of us and is the progressive evolution of our model of reality that we carry with us. That evolution requires that we have deconstructed and reconstructed this model repeatedly throughout our lives. However, to be in that moment after we have deconstructed our old model but before we have reconstructed our new model is a moment of chaos. This experience of chaos that each of us has had over and over is a dysphoric experience and one that all of us want to move away from as quickly as possible. That wanting to move away from this experience quickly gives us motivation to work hard at and quickly reconstruct our model of reality that serves us well evolutionarily as it would not be adaptive for us to be wandering around the world lost and defenseless. However, if we are to help others with this chaos, we must be able to tolerate it. With that intimate contact with a psychotic patient, the chaos that reigns in the patient resonates in the therapist. That is, the therapist can feel like they themselves are psychotic.

The experience of that moment is extremely dysphoric, has been referred to as annihilation anxiety (Benveniste et al. 1998), and is a state that few, if any of us, wish to tolerate for long (Fallon 2014). Therefore it is a reflex that we avoid this state in ourselves and also in our patients, since to be empathic with this state in another means that we allow it to resonate in ourselves. As therapists, we reflexively distance ourselves to avoid the extreme dysphoria that the chaos of psychosis brings.

Being aware of the dysphoria that empathic contact with the psychotic state engenders in us and developing the tolerance for this level of uncertainty and chaos are important qualities of a therapist who endeavors to use this approach. Open awareness (mindfulness) meditation is one way to practice and develop tolerance for this uncertainty in ourselves as therapists as a prerequisite for tolerating it in those who we might want to help. Be warned, however, that asking a patient to do meditation and tolerate this state when they are already suffering from an overload of uncertainty and chaos will likely lead to increased disordered thought in the patient. Therefore, we see that there is resistance within us as therapists to being empathic to the psychotic state in another. However, without this empathy, it is impossible to monitor the disorganization, anxiety, and disordered thought in another.

6.9.2 Barriers Related to the Family

The powerful deep conflicts in development which are the primordial nidus for most psychoses arise most if not all of the time in the context of developmentally important relationships that always contain strong ambivalences, particularly with parents, siblings, or even offspring as in the cases of postpartum psychosis. One can hypothesize that these conflicts occur because the attachment role needed in the development of new models of reality was not adequately fulfilled during the person's early development. This failure may have been due to attachment figures not functioning or to the maturing individual not being able to accept the support that was offered, or a combination of the two.

Nonetheless, we see the critical role of the failure of these relationships in the development of psychosis. This understanding is well established, and in fact one of the most effective interventions is to educate the family of the psychotic individual in providing support (Gottschalk et al. 1988). This education has been labeled as training the family in techniques of low expressed emotion. Its effectiveness is in providing support to the psychotic patient and avoiding increasing anxiety.

In addition, because development has gone awry, parents in particular continue to be critical elements in the patient getting back on developmental track. This is true even for adults who are psychotic. In fact it is quite common that adults who are chronically psychotic continue to be strongly tied to their parents, many times in a relationship that has a strong negative valence. This is why it is critical that family and, in particular, parents be involved in the work if they are available.

With the family involved, information about the core conflicts frequently comes to light, although it is important to be careful in engaging these core conflicts with the family, as manifestations of these conflicts, still unresolved, may be continuing within the family and the parents. Many times, resistance will develop within the family when the identified psychotic patient begins to get to the core conflicts. Occasionally, there will be opportunities to help the family and parents work through some of these core conflicts. Even in brief encounters, efforts should be made to include the family. It is important to respect this ecology. Chapter 8 addresses this topic further.

Conclusion

A developmentally informed psychoanalytic approach to individuals who are psychotic can be very useful, even in brief encounters. In order to do this work, to begin with, the therapist must tolerate considerable feelings of discomfort and internal chaos with empathic contact with the psychotic state. Therapists can be trained to develop tolerance to these feelings. A variety of methods such as regular supervision and mindfulness meditation are helpful in this regard. This empathic contact is necessary in order to track anxiety and disordered thought. This tracking is done by monitoring disorganization. Disorganization can be monitored through observing posture, physical moment, and speech production including porosity, cadence, and content. This monitoring then guides the therapist to provide minimal organizing support when increased disorganization is detected with the aim of preventing a downward spiral of degrading ego function. The effectiveness of this support is dependent on the patient's trust in the therapist's persistent ability to be empathic to the patient's internal experiences.

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