# Psychosis

## Functional Psychosis & Schizophrenia

*"Can I ever forget that I am schizophrenic? I am isolated and I am alone. I am never real. I play-act my life, touching and feeling only shadows. My heart and soul are touched, but the feeling remains locked away, festering inside me because they cannot find expression…." (New York Times, March 18, 1986)*

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## Introduction

Schizophrenia is one of the most debilitating disorders that affects 1% of US population and their families, with treatment costs totaling $19 billion and indirect costs totaling in excess of $46 billion. It strikes in late adolscence and early adulthood, derailing lives of its victims.

It can broadly be classified as a syndrome that embodies a heterogenous group, representing a common pathway for a number of disorders whose aetiology and pathogenesis may be quite different from one another (Buckley, 1988). However, it is perceived differently by different psychotherapeutic orientations, there being no consensus on what constitutes real schizophrenia. The most prevalent and widely accepted description and symptology comes from the medical model.

This paper is a brief exploration into the history of psychosis and how various streams of psychology define and treat this cluster of symptoms. The paper is divided into five sections that explore the successive layers of psychosis. The first describes the neurobiological findings, the medical research and contemporary approach towards schizophrenia. The second outlines the psychoanalytic approach to psychosis, the third section explores the analytical approach. The concluding section compares and contrasts the above, and provides countertransferential information that has guided this presentation. Although there is a significant difference between functional psychosis and schizophrenia, the term psychosis and schizophrenia have been used interchangeably in this document. Due to the limits on the size of this paper, the variants of schizophrenia (Schizoaffective, Schizophreniform & Delusional Disorders) have not been discussed.

## Section I : Neurobiological Findings and Contemporary Approach

### Clinical Presentations

The symptom list for scizophrenia includes positive and negative symptoms. Positive symptoms indicate presence of additional indicators. These are further divided into two clusters viz hallucinations and delusions, and disorganized thinking and speech. These symptoms are more responsive to psychopharmacology. Defining what constitutes delusions and hallucinations is subjective, depending on the treating physician/psychologist as spiritual experiences may often be technically classified as delusions/hallucinations by some, and not by others. Disorganized speech and thinking is a hallmark of psychosis, as is grossly disorganized behavior like wandering in disheveled state, randomly accosting strangers, standing at a street corner, staring at the sun, or catatonic behaviors like mutism, staring, social withdrawl, schizophasia (meaningless repetition of words), refusal to eat, marked rigidity, purposeless excessive activity, unusual postures etc and may cause intense distress in life functioning of the individual.

Negative symptoms are characterized by loss or diminishing of normal mental functions – blunted/flattened affect, social withdrawal, anhedonia (lack of pleasure/interest in activities), avolition, alogia (decreased fluency of thought and speech) and people appear disconnected, bland, zombie like.

The subtypes specified in DSM-IV (catatonic, disorganized, paranoid, undifferentiated and residual) may change over time. And although not a diagnostic criteria, lack of insight, or awareness of illness is a hallmark of psychosis (Amador & David, 1998). Suicidality presents an associated risk. Cognitive difficulties unfold across development, and include understanding and interpretation of emotional responses. The decline is not continuous, linear or progressive.

**Etiology**

The medical world is still unclear about the origins of schizophrenia. A chronic, severe and disabling brain disease[1] (Torrey, 2002) it is classified as neurodevelopmental in origin, being contingent on multiple factors - genetic, biological and environmental. The genetic/biological causes may range from genetic predisposition involving single, or multiple genes, to a viral infection that affects interaction between the genes and glial cells, to the presence of a tiny particle in the lumbar fluids of the people diagnosed with schizophrenia, a particle many label as a new form of life (BBC, 2002). No particular gene has been specifically implicated (Andreason, 2002, as cited in Woo & Keatinge, 2008) and according to the diathesis-stress model, a biological vulnerability is necessary but not sufficient condition for onset (Woo & Keatinge, 2008).

Neurodevelopmental impairments include a reduced volume (upto 25%) of gray matter in the brain, enlarged ventricles (Van Horn et. al., 1992), sulci, basal ganglia, decreased volume of prefrontal cortex and hippocampus, thalamus, posterior temoral gyrus, and superior temporal gyrus (Cornblatt, Green & Walker, 1999) and a hemispheric asymmetry. The shrinkage starts in the parietal, or outer regions but spreads to the rest of the brain "like a jungle fire" over the next five year period, especially to the temporal and frontal lobes (Berman et. al., 1991), dysregulaion of dopamine (and/or domanine receptor hyperactivity)(Whitaker, 2002) and GABA, glutemate and serotonin. MRI studies have revealed a dynamic wave of tissue loss that engulfs the brains of the schizophrenic patients. Symptoms include hallucinations, delusions, bizarre and psychotic thoughts, voices, and depression and impaired awareness of their illness (Amador & David, 1998). Although cognitive deficits are implicated (Drake & Lweis, 2003; Lysaker & Bell, 1995; Lysaker, Bryson, & Bell, 2002; McEvoy. 1996) the exact location where the disorder originates in the brain, is not understood (Sullivan, 1996). NIMH research indicates that the brain loss may be reversible and pharmaceutical companies are researching drugs that can accomplish such reversals.

**Treatment**

According to Woo & Keatinge (2008), treatment is long term, multimodal, and involves several areas of intervention and focus. The contemporary approach assumes medication is a necessary component of treatment, with psychosocial interventions as an adjunct to provide education about the "mental illness" and assist with coping strategies. The authors suggest the assertive community treatment model (ACT) that involves "a comprehensive range of treatment, rehabilitation, and support service utilizing a multi-disciplinary teams based in community" (p. 520).

Medication

The treatment of choice in the medical model consists of antipsychotics or neuroleptics. traditional antipsychotics like Haldol etc, or the newer atypical antipsychotics lile Clozapine, Geodone, Seroquel, Risperdal, Zyprexa, Abilify etc. Woo & Keatinge (2008) hold that although often effective, the drugs do not promise to cure, nor are they 100% effective for all patients.

Neuroleptics are known to be disruptive for the "neural pathways involved in the control of voluntary and involuntary movement" (Woo and Keatinge, 2008, p. 523). Research on patients treated with these drug show gradual decline of functional capacities, including tremors, muscular rigidity, movement disorders, akinesia, dystonic reactions, akathesia, obesity, diabetes, and elevated levels of prolactin – a protein the causes milk production in men and women, amenorrhea (absence

[1] E.F. Torrey's paper published in journal Schizophrenia Research (released September 20) confirms that schizophrenia is a brain disease, in exactly the same sense that Parkinson's disease, Alzheimer's disease, and multiple sclerosis are brain diseases. (web source)

of mensural period), gynecomastia (abnormal breast growth in men), bone loss and osteoporosis. Tardive dyskenisia, an irreversible neurological disorder occurs in 20%-30% of long term users of neuroleptics.

Psychotherapy

Eighty five percent clients preferred brief, less frequent sessions of reality-oriented therapy over insight oriented therapy (Coursey, Keller & Farrell, 1995 as cited in Woo & Keatinge, 2008). Gary, Fowler and Kuipers (2000, as cited in Woo & Keatinge, 2008) suggest Cognitive Behavior Therapy with 6 stages process :

1. engagement and assessment
2. coping strategy work
3. developing an experience of the psychotic experience
4. working on delusions and hallucinations
5. addressing mood and negative self evaluations
6. managing risk of relapse and social disability

PsychoEducation , Social Skills Training, Family Based Interventions, Vocational Rehabilitation : These are some additional areas of emphasis in contemporary treatment method.

## Section II: A Psychoanalytical Approach

Psychoanalytical understanding of psychosis is chiefly influenced by Freud, Melanie Klein, Otto Von Kernberg whose works we explore in this section.

Symptoms

London (as cited in Buckley 1988) classifies psychoanalytical symptoms of schizophrenia as :

1. Primary process imagery and mechanisms (archaic or primitive) involving introjects, indentifications and incorporative phenomenon characterized by disturbances in reality integration and drive integration.
2. Undifferentiated state of self and object representation, called fusion of self and object (Jacobson, 1954), symbiosis (Mahler, 1952) and projective identification (Segal, 1964) indicating regression to infancy prior to separation individuation.
3. Impairment in the constancy of self and object representations. Their attempt at recalling a person or experience evokes grotesque imagery and represents "impaired autonomy of evocative recall from drives" (London, nd), oftentimes such recall being completely unavailable.

Onset of acute psychotic episode may be heralded by a state of confusion and acute anxiety which is replaced by individual's sudden understanding of the meaning of experience. Bower (n.d) postulates that psychotic state of consciousness has elements in common with other altered states. The feeling of being transported beyond the self to a new realm, together with the affect of ecstasy and a heightened state of awareness is the same in both states. Lewin's (1950) work on the psychoanalytic explanation of elation is significant in understanding of the manic episodes of psychosis[2].

[2] Lewin (1950) suggested sleep and mania was a derivative of the intrapsychic fusion with the breast at nursing and he attributed oral eroticism to manic depressive illness. According to him, an "oral triad" was created as a manifestation of unconscious orality 1) the wish to devour 2) the wish to be devoured 3) the wish to go to sleep. He posited that all three had their origins in the nursing situation wherein the physiological need to eat and to sleep became psychological wishes. He stated that these wishes may "assume fantastic disguises and coloring" (p. 137) in a manic patient. He further sates that the ideas that have become differentiated as sleep, death, immortality, heaven, and the oceanic feeling all spring

Freud & the Psychoanalytic Cohort

Schizophrenic pathology is believed to occur when unconscious becomes conscious, when thinking falls back from the logic to prelogical levels and the primary processes and archaic ways of thinking come to fore again.

Person with schizophrenia is impaired in the use of past experiences (stable representational system) in its effort at making meaning out of external reality. The environment, limited by time and space, cannot provide that "consistency, the symbolic condensations or the range of patterns afforded by a representational system" (London, as cited in Buckley, 1988, p35). This impairment to organize ongoing experience also creates a faulty repressive function, enabling people with schizophrenia to express ideas and wishes that others have learnt to repress.

Whereas the neurotic avoids reality by fleeing from it, psychosis is typified by delusions and hallucinations and the abandonment/rejection and consequential remodeling of reality. Due to impaired reality testing, and their awareness of it, schizophrenics tend to be hypervigilant, expending above normal efforts at maintaining orientation in time, space and identity. Their concrete thinking thus is an adaptive defense against their impaired reality testing, a desperate need to remain grounded in reality thru accurate assessment of social reality – the defense allows them to perceive aspects of environment more accurately which others may take time to perceive (London, as cited in Buckley, 1988).

In terms of Freudian structural definitions, the neurotic ego depends on reality to enable suppression of id. The ego withdraws from reality in the service of id and psychotic experiences are suffused by loss of reality whereas neurotic experiences tend to avoid this loss. The superego is projected and appears as auditory hallucination and delusional ideas (Fenichel, 1945). The distorted externalization of inner conflicts causes hallucinations, delusions and paranoia. These defenses serve as "an attempt at recovery, a process of reconstruction" (p. 71), a restitutive, self-reparative function. This concept has medical legitimacy because the high production of adrenocortical harmones ( their levels provide a measure of stress during the onset of acute psychosis) drop down rapidly with the appearance of delusions in patients (Sacher, et al, 1970).

Freud's Classical Theory leads to two theories of schizophrenia. The Unitary Theory is based on intrapsychic motives that are primarily the same as those of a neurotic, only larger in the degree of conflict. Thus schizophrenic behavior, viewed thru the lens of Unitary Theory, is a more severe form of neurosis, the implication being that anyone can develop schizophrenia given a certain degree of unmanageable intrapsychic conflict.

Freud's more acceptable theory, the Specific Theory of schizophrenia, proposes that schizophrenic behavior is unique and separable from other behaviors. The concept is expressed as "withdrawl of cathexis [decathexis[3]] from the mental representations[4] of the objects," such behavior

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from the matrix of subjective experience found following nursing. The content of the manic ideas includes "later events of childhood which themselves in some ways repeat or revive the nursing situation or may have been falsified by it" (Buckley, 1988, p. xxix)

[3] Schur (1966) held that normal development was driven by pleasure and unpleasure principles. The pleasure principle is guided by the need to recreate the experience of satisfaction thru elimination of drive tension. The unpleasure principle regulates the need to withdraw from excessive stimulation impinging on themental apparatus from the outside. Eventually, thenecessity extends to the withdrawl from the memory traces of such stimulation. Such disturbance in the capacity to organize memory traces into mental object representations as to sustain mental object representations. . .rooted in developmental factors which are superordinate to the development of the instinctual drives, is linked biologically to the withdrawl responses of psychosis, being regulated by the unpleasure principle (as cited in London, nd).

[4] "mental representation refers to the mental organization of memory traces; memory traces deriving from experiences involving internal and external stimulation and the responses of the stimulated subject" (London, n.d.)

being reactive to the "internal catastrophe" or cathectic withdrawl. Schizophrenia appears as an adaptive response to a psychological deficiency. Freud believed psychosis did not lend itself to psychoanalytic treatment because such patients were impaired in thinking, free associating, and hence incapable of sustaining mental representations of external objects, which made transference impossible.[5]

Kleinian Perspectives

Melanie Klein believed that the fixation points of psychosis were to be found in the earliest months of infancy. She believed psychosis to be an outcome of impairment in the process of symbol formation. She saw that children under the sway of anxiety were constantly trying to split their feelings and their objects into good and bad, attempting to retain good feelings, internalize good objects while expelling bad objects and projecting bad feelings. The main anxiety in the paranoid-schizoid state is that the persecutory object will get inside and overwhelm and annihilate the ideal object and the self. "in situations of anxiety the split is widened and projection and introjection are used in order to keep persecutory and ideal objects as far as possible from one another, while keeping them both in control" (Segal, 1973, p. 26). Rapidly fluctuating situations may cause persecution to be felt either as an external threat or an internal hypochondriacal fear.

Later work by Kernberg and Jacobson is based on Kleinian concepts of internal good and bad objects, splitting of objects, self and object fragmentation, the projection of bad object, the massive anxiety engendered by destructive aggressive fantasies. However, this raw appearance of primitive infantile elements in the symptoms of psychosis is questioned by psychoanalysts who view the fears, fantasies, and thoughts as manifest contents whose latent meaning can only be obtained thru associative material (Buckley, 1988).

Many papers have been written on schizophrenic's powerful tendencies towards incorporation or introjection: a tendency that leaves him vulnerable to the therapist's unconscious processes (Numberg, 1921; Abraham, 1927; Bychowsky, 1930, Allen, 1930, as cited in Searle, n.d). Drawing from these vulnerabilities, Searle maintains that schizophrenic acting out may be a response to, or vicarious expression of the therapist's unconscious processes.

## Section III : Analytical Perspectives

> *To be normal is a splendid ideal for the unsuccessful, for all those who have not yet found an adaptation. But for people who have far more ability than the average, for whom it was never hard to gain success and to accomplish their share of the world's work – for them restriction to the normal signifies the bed of Procrustes, unbearable boredom, infernal sterility and hopelessness. As a consequence there are as many people who become neurotic because ethey are only normal, as there are people who are neurotic because they cannot become normal. (Jung)*

Analytical psychology considers psyche to be more powerful than the mind or the body, affording it almost a sacred place in the hierarchy of existence. The following explores the works of

[5] Bowers (1974, as cited in Buckley, 1988) suggested a biological predisposition model to an altered state triggered by psychic conflicts. The model suggests a psychosomatic relationship that integrates biological and psychological perspectives and three main determinants to psychosis – 1) Altered state of consciousness like heightened state of awareness, intensification of sensory experiences, alterations in the sense of self, externalization of conflict, invasion of perceptual and cognitive modalities 2) Idiosyncratic determinants of structure that determine the content of psychosis. These reflect the psychology, history and intra-psychic conflict. 3) The time of the psychotic episode is contingent on the life events and developmental challenges faced by the individual.

Jung[6] and Stainslav Grof. The simplest explanation of Jung's (1960a) hypothesis holds that the onset of psychosis begins with "weakness" and "sensitivity" in the mind, or a predisposition that allows a strong affect to initiate a certain moodiness followed by a complex. These complexes function as black holes, sucking all activity – intrapsychic or interpsychic – and the psyche can never rid itself of them. Associate blockings of psychosis (thought deprivations) are a consequence of thoughts being sucked into such a complex, and as it affects more and more thoughts, the person deteriorates linguistically and psychically causing word salad formations and stereotypical obsessions. The split off complexes may invade personality alternately that causes bipolarity of behaviors. Though atrophy of the complex reduces the degree of distress, "the complex itself causes extensive destruction of personality, and the schizophrenic at best escapes with a psychic mutilation" (Jung, 1960b, p.97).

The psychological content of psychosis, according to Jung, is derived from person's intraversion, personal conscious, as well as the collective unconscious, "a restless creative fantasy which is constantly engaged in smoothing away the hard edges of reality" (Jung, 1960a, p. 177). And his theory of opposites posits that normally the internal compensates for the external, the unconscious compensating for the conscious – establishing a homeostasis that enables day to day functioning for all of us. The unconscious holds these compensatory functions internally in specific formats that are different from their conscious counterparts. These compensatory influences consist of typical attitudes, modes of actions, thought-processes and impulses that are a treasure-trove of behaviors available to human species, and exist as archetypes. These are held in thru repression and are guarded by various forms of resistances. When the external experiences distress and is perceived to need significant compensation, the unconscious attempts compensatory influence in order to maintain the homeostasis.When an archetypal energy is needed to compensate an external/conscious deficit, it breaks thru into conscious mind. While crossing the boundaries of the unconscious it encounters layers of psychic resistances that separate the unconscious from the conscious. Distortions in the contents of the archetype are introduced in the process of overcoming these resistances; the distorted archetype then proceeds to make itself heard/visible in the "language" of the conscious mind, causing additional "translation errors" that add to the distortions. The process is analogous to the game of Chinese Whisper with all its inherent distortions of content. The distortions appear threatening to conscious intelligence and the individual attempts to fight these compensatory influences, ie he fights his own unconscious strivings. As Jung succinctly puts it "the function of the unconscious in mental disturbances is essentially a compensation of the conscious content. But because of the characteristic one-sidedness of the conscious striving. . .the compensating correctives are rendered useless" (Jung, 1960a, p. 210). The contents are not merely archaic, "but are also distorted by their chaotic randomness" (Jung 1960a, p. 263).

Jung's (1960a) suggests that schizophrenia involves splitting of personality into splinters (like a mirror breaks). Each split off figure (complex) assumes "banal, grotesque, highly exaggerated name or character" (p. 235) that intrudes uninvited on the conscious ego. These autonomous figures (complexes) are not under the control of the ego. Whereas neurosis entails partial dissociation, and partial loss of personality, schizophrenia is absolute, and Jung believed, largely irreversible. He equates schizophrenia to a "big dream" in that it exhibits "the same numinous quality which in primitive cultures is attributed to magical ritual. . . he is invaded by autonomous figures and thought forms" (Jung, 1960a, p. 243). He further states that the primitive chooses not to feel invaded by unconscious material, but feels strengthened by it.

[6] Jung's work on psychosis resulted from his research that culminated in the publication of ***The Psychology of Dementia Precox*** which led to the formulation of his theory of affective complexes.

Schizophrenic complexes, Jung notes, do not draw energy from other mental processes but seems to devour its own energy, abstracting from its own contents, manifesting as disintegration of means of expression and communication and "inadequate inaffectivity." Complexes, he asserts, generally normalize themselves by fitting into the hierarchy of higher psychic structures, or by producing dissociation consistent with ego personality. In schizophrenia, the complex remains archaic and "fixed in a chaotically random condition, regardless of its social aspect. . .alien, incomprehensible, incommunicable," (p.270) like majority of dreams. Just like the sleep state is responsible for dream, he believed that a toxin produced in brain may have the noted effect on localized archetypes in the subcortical region. He believed that discovery of such a toxin would validate the process of self destruction of the complex that he had emphasized.

Following a constructivist approach towards investigation, Jung (1960a) believes that psychotic activity follows neurotic activity, except that the psychotic does not have the "same certainty with regard to his foundations" (p. 258). Hence he believed that "the thoughts of the patient must be taken seriously and followed out to their logical conclusion; in that way the investigator himself takes over the standpoint of the psychosis" (p. 191). Jung's (1960a) treatment for psychosis involves creative expressions so that "the chaos of his total situation may be visualized and objectified; it can be observed at a distance by his conscious mind, analyzed and interpreted" (p. 260). He asserts that the psychological conflicts inherent in psychosis cannot be "dealt with. . .by means of distraction reason and self control," and that psychosis is a result of panic that arises when it becomes known that there is no help available to solve the psychological problems. He believes that if these internal conflicts are resolved prior to the panic stage, outbreak of psychosis can be avoided for that incident. Hence Jung's "method" for treating psychosis and schizophrenia is subjective, varying with the needs of the patient.

Stanislav Grof's (1989) work in functional psychosis bears special mention in understanding a derivative of psychosis like states in spiritual environments. He holds that the anatomical, psysiological or biochemical changes in the human brain lead to organic psychosis but there exist other forms of functional psychotic states for which no medical explanation has been found, and yet these get clubbed under medical diseases. Analytic psychology observes the expression of the mental contents that emerge under nonordinary states of consciousness as "manifestations of the deep recesses of the human psyche that are not ordinarily accessible" and holds that the surfacing of this unconscious material can actually be healing and deeply transformative (Grof, 1989). Labeled as Spiritual Emergency (Grof, 1989), such states are triggered by a powerful emotional experience, like death or divorce, but can also be triggered by meditative spiritual experiences. These experiences undergo three different stages:

1. Biological aspects of spiritual emergencies entail reliving and healing of traumatic events from one's own life.
2. The perinatal theme centers around remembering experiences of dying and being reborn
3. Transpersonal, spiritual, mystical, occult, magical or paranormal experiences involve experiencing geographically remote events, melting of personal boundaries, also including deities, demons, spiritual guides etc.

Grof (1989) suggests that spiritual experiences mislabeled as psychotic breaks under modern medicine include the shamanic crisis, the awakening of kundalini, episodes of unitive consciousness, psychological return thru the return to the center, the crisis of psychic opening, past life experiences, communication with spiritual guides and "channeling", near death experiences, experiences with close encounters with UFOs, possession states etc.

## Section IV: Conclusions & Countertransferences

### Comparison

The three approaches to psychosis represent varying perspectives and understanding of the problem labeled as psychosis, and at first glance appear as distinct, contradictory methods of treating the disorder. Upon closer scrutiny, one can almost conceptualize them as representing and interacting with various layers of our subjective reality (Mathews, 2008). The outermost layer is represented by the analytical psychology approach that addresses the collective and mythological dimensions of the psyche, the psychic DNA and embedded inherent existential human suffering. The second addresses layer represented by the personal unconscious created by the environment. It concerns itself with issues where "mind's capacities are stretched to deal with such challenges as conflict, anxiety, overwhelming affect, trauma, unusual family patterns and biological differences" (PDM, 2006). The medical model with neurological research and Cognitive Behavior Approach represents the material, or physical layer. Whereas the first addresses the long term desire of the soul to heal, the second heals the impairments of personal unconscious, the personal psyche and the third heals the body, and enables day to day functioning. As such, these seem complementary rather than competitive approaches to healing.

However, the side effects introduced by neuroleptics, in my humble opinion, do more harm than they do good in many cases. They cause psychological arrest of the person in his healing process, More than 60% of the patients seem to deteriorate despite (or because) of neuroleptics, and suffer their secondary effects. Medication free treatment is available all over the world, but very little is being publicized in the US because of the political hegemony of pharmaceutical companies, which promote drugs that may have a crippling effect on certain population.

Countertransferences

I am a member of ICSPP, and a follower of Dr Peter Breggin, the author of Toxic Psychiatry. For my PhD practicum, I trained in Dr Kevin McCready's clinic that specializes in providing medication free treatment thru analytical psychotherapy based on creative endeavors like art, play, music and dream analysis. The client-base included, among others, people diagnosed with psychosis and schizophrenia. In my current private practice, I facilitate a medication free environment and have helped patients reduce their dependence on prescription medication. I believe that medication is antithetic, even toxic to psychological healing. These countertransferential biases makes me partial to Jungian approach to treatment of psychosis, and may have affected the quality and quantity of information provided in this paper.

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