COMMENTS ON PSYCHOSES and ON CREATIVE WRITING

Two items to bring before you: We begin with how I hope to encourage the development of your spontaneity and creativity through writing, which has been a major resource for me. We have the Newsletter, distributed now through the internet, which means we're without space restriction. There's room for your creation.

If you write down your reaction to our programs as soon as possible, you'll be amazed at how much you remember, and what is even better, you'll automatically include your own reactions, for you'll be freer to express yourself, without some presumably critical person listening. Of course you critique yourself, but you'll have much more to go on if you have something---anything---down on paper. Back in the 'dark ages' as an undergrad, I overcame a tedious compulsion to highlight readings when I discovered (just in time) how much examination preparation improved with closing the book and reacting on paper.

I confess, Ever since childhood I've wanted to be a writer, a common ambition The trouble is that this often represents only the wish to have written, rather than to engage in the process of writing. O the lure of the 'bottom line. Committed to writing every day, I enjoy the satisfaction of never facing "a writer's block." Whatever is in my head goes to the paper. I don't wad it up after only a half sentence, litter the floor, and begin a clean sheet, like they dramatize (frustrated) writers in the movies. Whoops! That's an anachronism. Today's computers do an 'end run.' What a relief to keep on going. Delete later, when enough's there to take the trouble.

To be more specific. I'm suggesting how we may make the best use of what information comes our way. Not so much to retain what we've heard, but to discover what I, myself, feel about it all. I've come to the place in life where I set my experiencing where it belongs, in the midst of what I'm already coming to know and do. We call it integration, even if it's not yet inspiration. No peaks emerge except to interrupt the valley of the ordinary.

A next step.

What do I want to share and with whom? I've already wrestled with myself, so I don't need to do that again. Who is your target audience? You have something to say, so say it! We're listening. My attempt to be a role model leads me to the second item cited at the beginning. I've lived long enough to plunge on into whatever interest dominates me at the time that I've almost incidentally fully qualified myself to work in four or five vocations, depending on how you count them. What matters here is not the story of my life, but only what is pertinent to our most recent experience together. At IE-CAMFT last month, our speaker on psychoses prompted reflections I'll share to reduce anxiety and stimulate your professional progress. My 'second profession' was clinical psychology, which fed my curiosity all the way through a two year hospital internship on to the doctorate in 1956.

You may lack confidence in the extent of your formal preparation in this particular area. Don't panic. You may know more than you know. Are we not all human

beings serving other human beings, who need our help? And so we help one another here. I use personal references in the hope I can make them work for me. Others are prone to remember the personal, and more readily recognize parallel experiences. Think of that as you heed my suggestion to write for our newsletter. We're preparing for no greater examination than what working life thrusts upon us.

Use your computer resources (or reference librarian) to scan ***The Snake Pit,*** .a vintage forties movie, What the protagonist faced in her asylum hospitalization is what I found on the ward of a traditional state hospital back then. This was prior to the coming of tranquilizing drugs, when psychotherapy was a psychiatrist's prime function, jealously guarded against 'insidious' incursions of psychologists. Psychiatrists took social workers more in their stride, who worked with 'obnoxious' families and waded through picky bureaucratic work the doctor would have to do.

Actually MFTs today may profit from the history of all three professions, and not fritter away valuable time on 'internecine wars.'. "Whoever doesn't know history is compelled to repeat it." Commercial publishers and librarians seeking shelf space, evaluate mid-century writings as obsolete, but I object, for how we saw things then has its counterpart in what we do today. Don't be overly impressed with the subtle (and sometimes not so subtle) pecking order mental health professionals sustain. Your expertise may equal or excel those 'above' you, despite their greater prestige. Make more consultations but fewer referrals. Your patient may be better off to stay with you.

Quickly my initial 'Snake Pit' perception faded as I logged more time on the ward, alone with the patients. When I listened to what they had to say, without hastening to advise, they taught me more than they realized about themselves--- and more than I had realized about me. Like children, their frank comments may sting, just because they're often accurate. But can I be offended? What's true is true. Best to swallow the bitter pill, for when we do, we cross a threshold. No need to defend a power position. Indeed, it becomes more powerful when we don't. When we make contact, we're making progress. We've reached 'first base.'

How different this is from how I self-consciously functioned in my professional role as diagnostic psychological examiner. I blush as I remember how psychiatric interns hung on every word of my report. They were struggling with the book learning burden of their medical education, and the unquestioned assumption of 'superiors' that there is an essential connection between diagnosis and therapy. As it happens, it's not very close, even though DSM 2, the diagnostic classification system in use in my heyday was terse indeed. One could start after breakfast and be finished reading before lunch. Yet I regard it as more practical than anything we've come up with since.

There are fundamental problems we like to label 'philosophical' so that we can forget them. We tend to think of schizophrenia as a condition the patient has, just as the word "fastidious" refers to a trait your annoying roommate possesses. In DSM-2 not many noted the emerging glimmer of hope. They list not merely 'schizophrenia,' but 'schizophrenic reactions'.

One is not a 'schizophrenic.' nor is one an 'obsessive.' There are no obvious disease entities which better chemistry can cure. So what is the (pardon me) 'schizophrenic' **reacting to?** Hardly to an identifiable physiological process within himself, though counterparts necessarily exist, for the human being is one organism. Often it is convenient to research neural limits, to inform what we're doing psychologically. rather than come up against a stone wall in attempting the impossible.

Our justice system daily deals with murder. What was the cause of death? The DA says the defendant is the cause of death. If pressed, he'll concede it was a '38 revolver,' or a bullet in the heart." but the medical examiner's report details other "causes." Can all these be true? Of course, they are alternate levels of explanation for the same incident. My point? If we fully explore our own accustomed level of explanation in terms of social interaction, we'll have fewer worries about possible medical involvements. Medicine has its own individualistic 'biases' which overlook the vitality and competencies or our profession. When the doctor 'lets slip' or outright tells the patient his diagnosis, he overlooks the patient's identity confusion, for the diagnosis may become a self-fulfilling prophecy. I understand the rationale behind it, but I cringe at the AA routine of a speaker's introducing himself, "My name in John Jones, and I'm an alcoholic." Believe me, he's much more than an alcoholic, and if he gets in touch with the 'much more' the alcoholic identity fades. To speak of 'acting crazy' is better than latching on to the label 'psychotic.' Ordinary English is less likely to mislead. Take the imaginative leap into another's shoes, and you'll find what is before you is not so strange after all.

It's difficult today to find the learning opportunities I enjoyed. State hospitals have been emptied. Getting internships, at least paid internships, is nearly impossible, and even if you were to land an attendant's job, all the patient symptoms have been masked by elaborate drug regimes, the effect of which takes time to discover. The physician who prescribes them has the same problem, so don't feel bad. Moreover, you have been dropped into a culture (consult an anthropologist) which proscribes what you may or may not do. Not much space for validation of your hypotheses! One important thing you'll learn is not to be afraid. You've seen others be reckless, and you'll not repeat their mistakes. The trouble they face is oft brought on by themselves. They'd probably have the same trouble in a factory, though the day of reckoning may take longer.

When our speaker cited the ethical necessity of referring 'psychotics' it gave me pause. Of course we must be ethical. But how do we know that's what we're dealing with? Perhaps we've discovered the condition ourselves in the course of treatment, If our client has a history of hospitalization, and mentions casually in passing "life is not worth living," or "I'd be better off dead," that's a red flag. Don't ignore it, as if it will go away after a night's sleep. But don't call '911' either. Encourage: "Tell me more about that." Focus on the feeling. We know he's depressed, but what's beneath that? Fear and anger are likely. One feeling may be at the door, with the other, unrecognized, behind it. "Have you ever felt like this before? What

happened? Do you expect it to happen again?" Most of your clients will perk up, become more animated, for the relevance is obvious. The decision you must make as MFT is not whether the client is psychotic. He may or may not be. The question is "Do you conclude he is a danger to himself or others?" That's when I'd say "I don't want any harm to come to you, so I suggest we consult someone else, family or colleague." "Is he on any medication? What is it?" It helps to know what the more common meds are for. "What does it do for you?"

What goes through the client's head is "Ouch, she knows I haven't been taking my meds." Before she can decide to lie, I ask (I should already know) "Who is your doctor?" Intuitively she recognizes that there are no secrets from the primary physician. She may plead, "Don't say anything to my doctor." That's when I say, "Let's trade chairs." That done, I say "In my chair over there, you are me, but from your chair here I'm going to pretend I'm you. Now I shall repeat your sentence, and you respond as if you were me, in any way that you think is right." Having done so, "Now let's go back to where we were." I repeat the words she'd put in my mouth, and her response, whatever it turns out to be, puts us in another ballpark. You'll know what you should do. It's important that the client not feel like she's failed again, and know that you, at least, care about what happens to her.

Where does 'psychosis' fit in here? The word describes one with a fleeting grasp of reality. The procedure cited above gives you an avenue for making a good guess, but what matters is what you do, rather than worry about the diagnostic label. If there is a complication, and you don't want to treat the client yourself, refer. When and if I do, it's based on my knowledge of me, and how I relate with clients, not on the diagnostic label.

If your client seems strange or puzzling, and hides his feelings, so that facial expression doesn't match what he's saying, a schizophrenic process is possible. Don't underestimate the fear component. I ask about any dreams, particularly recurring nightmares. If the manifest content has one being consumed by fire or water, or being frozen, this is a red flag. But I don't say this out loud. Does the client's life story sound like a dream rather than a social commonplace?

I consider my options. The setting where I work is a major factor. Alone in private practice involves more risk, but if I'm working in a clinic or hospital situation I may speak with a colleague. Of course you have to take into account what confidentiality means where you are. For ten years I worked at a private psychiatric hospital in Pennsylvania, where confidentiality was shared by the whole medical staff, at least in the notes we put into the clinical record.

Parenthetically, I disdain technical language, so that even if the patient were to read what I wrote, he'd not be affronted. Indeed, sometimes the patient's psychiatrist would read aloud what I said, and the patient never complained. If in doubt, I get the client's permission to speak with another professional, who can help me help him. I'll name who I have in mind, for my colleague is known at least by reputation to the client. It protects both therapist and client to share responsibility. If anyone should report to the board, or take the matter to court, the evidence is in your favor.

If I expect scrutiny by the licensing board, of course, I put treatment plans into my computer, along with what I consider progress, given this or that. The MFT frame of reference should be quite adequate. The structure suggested by Bowen, for example, allows for change as client's mature. What we're treating is the story of human interaction, as we work toward improved functioning and more personal satisfaction. The 'deep' intrapsychic comes in only as interaction is affected. Once surfaced, it becomes interpersonal, which is our arena.

Remember that the whole diagnostic system. with its emphasis on individualism, is alien to all you've been doing. Only if the client is unable to function in everyday life should we consider bowing out of the therapeutic relationship. It is a matter of your judgment before it is anyone else's. But then, make sure you have consultant or supervisory resources. That should be enough to keep everyone safe.

Here are a few generalizations you'll not find in the textbooks. Normally we work with what psychiatrists call 'neurotics.' We know how to do that. What treatment adjustment do we make when we suspect psychoses? With neurotics we uncover and ventilate, but with psychotics (at least in the short run) we cover up and provide limits. We make our usual 'neurotic' client aware of 'defense mechanisms,' for he's 'well defended.' Indeed, he's overdone it. Defense against what? The bubbling caldron of the as-yet-unstructured 'primary processes,' the 'unconscious', the chaotic heritage we seek to replace with consciousness.. (See Anna Freud, "The Ego and the Mechanisms of Defense") Pierce those rationalizations and reaction formations.

Quite otherwise with 'psychoses.' Support rather than oppose neurotic defenses, for with psychoses the patient is poorly defended. He relies on primitive defenses such as denial and dissociation. Delusions and hallucinations are attempts to compensate for the damage they allow. With the latter the process is already far along. The trick is to build up the defenses before they go so far.

How? For me the best resource is a cohesive accepting group. Even a group made up entirely of patients diagnosed schizophrenic has a more adequate sense of reality as a group than any of them have as individuals. Lacking an available group I'm careful to maintain a positive relationship and remind the patient of reality boundaries as they arise. Never scold. Validate desperate attempts as increments of progress. He can count on you to understand.

Isolation is your worst enemy. Although you keep your professional boundaries as much as possible, emergencies arise demanding you bend the rules. Beware of distancing. That's when bad things happen. Whatever your limitations, because of your relationship, you may be the best one for him It's scary, but you are the patient's lifeline. His regard for you may save him.

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