CBT for psychosis in a psychoanalytic frame

Michael Garrett*, Douglas Turkington*

* SUNY Downstate Medical Center, Department of Psychiatry, Brooklyn, NY, USA

Online publication date: 31 January 2011

To cite this Article Garrett, Michael and Turkington, Douglas(2011) ‘CBT for psychosis in a psychoanalytic frame’, Psychosis, 3: 1, 2 — 13

To link to this Article DOI: 10.1080/17522439.2010.544403

URL: http://dx.doi.org/10.1080/17522439.2010.544403
CBT for psychosis in a psychoanalytic frame

Michael Garrett* and Douglas Turkington

SUNY Downstate Medical Center, Department of Psychiatry, Brooklyn, NY, USA

(Received 21 October 2010; final version received 29 November 2010)

Some clinicians regard psychodynamic psychotherapy (PP) and cognitive behavioral therapy of psychosis (CBTp) as treatments with little in common. An integrated model is presented in which PP and CBTp fit together, with each modality playing an essential role in different ways at different points over the course of treatment. This model is developed by examining a core symptom in psychosis. Psychotic individuals seemingly perceive events in the outside world which are actually reflections of internal mental processes. Instead of experiencing thoughts or feelings, a person “sees” or “hears” things which appear to be occurring outside the self, a “thing presentation” of mental life. Before the unconscious meaning of psychotic symptoms can be psychodynamically interpreted to a person, “thing presentations” of mental life must first be returned within the boundary of the self. CBTp provides the technical means to do this. Once CBTp has helped re-establish connections between psychotic experience and internal emotional life, a psychodynamic perspective becomes increasingly important. In this model treatment begins with CBTp practiced in a psychoanalytic frame, followed by a second phase of treatment in which PP bears empathic witness to a person’s mental life, nourishing self experience.

Keywords: psychosis; schizophrenia; psychotherapy; psychoanalysis; delusion; hallucination

Introduction

In the last century, psychoanalysis has produced a small number of clinicians with a gift for working with psychotic patients, but never a treatment that can be implemented in community clinics where most chronically psychotic individuals are seen (Arieti, 1974; Stone, 1999; Willick, 2001). Said another way, psychoanalysis has produced a limited number of Maseratis, but never a family sedan the average well-trained clinician can drive. Meanwhile, cognitively oriented researchers and clinicians in Great Britain and elsewhere have made gains in cognitive behavioral approaches to psychosis (CBTp) (Morrison, 2009; Tai & Turkington, 2009; Wykes, Steel, Everitt & Turner, 2008). Why have psychodynamic approaches shown limited growth while CBTp has continued to expand? The reason isn’t that psychoanalytic ideas are irrelevant to the treatment of psychosis. Rather, psychodynamic technique has paid too much attention to the interpretation of unconscious mental processes underlying the psychosis, and too little attention to the conscious experience of the psychotic

*Corresponding author. Email: michael.garrett@downstate.edu
symptom perceived as an event in the outside world. A modification of psychodynamic technique is required.

While psychoanalysis defined as treatment on the couch will never have a place in public psychiatry, psychoanalysis defined as a collection of psychological ideas has much to offer. A psychodynamic perspective promotes empathy, which helps establish initial engagement and sustain the therapeutic alliance. It contributes tact and timing to CBTp interventions. Psychoanalytic object relations theory is extremely useful in understanding the meaning of hallucinations and delusions, stressors and trauma, and how self-esteem is regulated (Klein, 1935). Psychodynamic skills are essential in extended treatments. CBTp and psychodynamic psychotherapy (PP) should be fit together in specific ways at specific times over the course of treatment.

We will describe an integrated model in which CBTp technique initiates treatment and defines the basic structure of the initial phase of psychotherapy, while psychoanalysis provides a psychodynamic frame which lends depth of emotional understanding, tact, and timing to the treatment process. During this first phase, direct psychodynamic interpretation of the unconscious meaning of psychotic symptoms is rarely useful, but may be important later in treatment, depending on the needs and capacities of the patient. After a course of CBTp, a second phase of long-term follow up ensues where traditional psychodynamic skills are of paramount importance.

Why integrate CBTp and PP? First, an integrated model which broadens our theoretical understanding of the pathogenesis of psychosis promises improved technique. Second, integration is important in fostering interest in psychological treatments of psychosis. There are many psychodynamically trained clinicians working with the chronically mentally ill whose work with psychotic patients would be improved with the addition of CBTp techniques. Psychodynamic clinicians may be slow to seek CBTp training because they believe CBTp is at odds with their psychodynamic identity, and the same for CBTp clinicians. CBTp clinicians unfamiliar with the psychoanalytic literature may fail to take advantage of psychoanalytic ideas which would enrich their work. This paper attempts to show there is room at the table for all, and where each should sit, to combine forces toward the common aim of better patient care.

While other approaches to integrating CBTp and PP have been suggested (Hingley, 1997; Margison, 2005), we will develop an integrated model by examining a core symptom common in psychosis, the mistaken belief that events are occurring in the outside world which are actually occurring in the person’s mind. All hallucinations, most delusions, and psychotic symptoms such as ideas of reference are examples of this phenomenon. Both CBTp and PP clinicians recognize the central importance of this inside-becomes-outside phenomenon, but call it by different names. In Garety’s CBTp model of psychosis (Garety, Kuipers, Fowler, Freeman & Bebbington, 2001), a triggering event in a person biologically, psychologically, or socially predisposed to psychosis leads to stress, altered physiology, distorted cognitive processes, and anomalous subjective experiences. In this model, the anomalous experience itself does not constitute the psychosis. Rather, the mistaken metapsychological judgment that the inner experience is occurring in the outside world constitutes the psychosis. From a psychoanalytic view, although he uses the term differently than Freud (1915), Marcus has described the experience of a thought or feeling as an external perception as a “thing presentation” of mental life, i.e. the psyche is manifest through the perception of things in the outside world (Marcus, 2003). “Thing presentations” are a special form of thinking in images. Out of defensive need, thoughts are projected into mental repre-
sentations of animate and inanimate things and experienced as though located in the outside world (Bion, 1957). Traditional PP reaches its limitation because it does not provide an effective technique for dealing with “thing presentations” of mental life. CBTp provides this technique.

Consider an example of inside-becomes-outside. A 40-year-old man believed himself a failure after he had his first psychotic episode in the military, a belief compounded by his younger brother’s death in a drug-related slaying. He blamed himself for not leading his brother to a better life. The patient explained to his doctor he never left his house because he could tell by the way dogs in the neighborhood looked at him that the dogs could see through his clothing, exposing his puny body underneath. He believed the dogs were mocking his physique with their glance. The dog’s eyes are a “thing presentation” of his self-recrimination. In CBTp terms, the patient has made a mistaken metapsychological judgment that he is experiencing an interaction with a dog rather than a self-critical thought. In the language of psychoanalytic object relations theory, the patient’s mental representation of the dog corresponds to an internal object which has become the container for the patient’s projected self-hatred (Klein, 1946). When he is focused on the dog, the patient’s painful self-criticism has gone missing from his own subjective experience, only to reappear in the mind of the dog. Intrapsychic pain has been transformed into an interpersonal problem between the man and dog. Fight or flight from an external danger is now possible. By not leaving home he avoids the dog, and in so doing he attempts to avoid his self-hatred.

In PP, the therapist follows the patient’s free associations, and attempts to identify the unconscious mental content which is giving rise to the patient’s symptoms. For example, an anxious non-psychotic patient reported being unable to make a phone call important to her business. Unlike the psychotic patient, there was no “thing presentation” of her conflict. She knew the problem was in her mind. After the unconscious meaning of the phone call was brought to consciousness, the patient was able to make the phone call. Even when the link between the psychotic symptom and its unconscious origins is fairly clear, as in the case of the mocking dog, why is the interpretation of this psychodynamic link rarely of value early in treatment? Psychodynamic technique has paid too much attention to the interpretation of unconscious mental processes underlying the psychosis too early in treatment, and too little attention to “thing presentations” of mental life, the conscious experience of the psychotic symptom perceived as an event in the outside world. Before the psychodynamic meaning of a psychotic “thing presentation” can be interpreted psychodynamically, the treatment must first return the patient’s experience to the inner world of thought and feeling. CBTp provides the means to do this. In psychoanalytic terms, CBTp provides a massive reinforcement of the patient’s observing ego, which allows the patient to consider alternative explanations for his experiences.

The metaphor of a volcano may help to contrast CBTp and PP. In a volcanic eruption, molten lava (the psychosis) extrudes under pressure from an underground chamber (unconscious mental processes). After it cools on the surface and hardens into rock (crystallizes into a psychotic symptom), it is no longer directly subject to the pressures of the lava below ground. Once the unconscious has hardened into a “thing presentation”, its connection to its unconscious origins has been effectively severed. It is now a memory of a perception connected to other memories and perceptions rather than a thought or feeling connected to unconscious meanings which can be interpreted to the patient. In psychosis, perception is corrupted by psychodynamic
processes without the patient knowing this has occurred. Not only that. Because the capacity for logical thinking is preserved in psychosis (Kemp, Chua, McKenna, David, 1997), patients use logic to make inferences which link sequences of corrupted perceptions into systematized delusions. Patients believe they are relying on perception and logic to define reality, as they always have, which is a particularly insidious aspect of psychosis. Psychoanalytic interpretation seeks to attack the psychotic symptom from below, by interpreting the underlying unconscious dynamics which gave the symptom its origin and power. This is ineffective because the symptom psychologically resides in the external world. CBTp provides a technique to chip away at the “thing presentation” of the psychosis from aboveground, in the conscious, perceptual space in which it has hardened into memory, to slowly re-establish a connection between the psychotic symptom and the patient’s internal mental processes.

### Cognitive behavioral therapy of psychosis (CBTp)

CBTp is one therapy among many modalities useful in the treatment of psychosis, including family therapy, milieu therapy, group therapy, and the judicious use of antipsychotic medication. Numerous textbooks describing CBTp at length are available (Beck, Rector, Stolar & Grant, 2009; Chadwick, Birchwood, & Trower, 1996; Hagen, Turkington, Berge & Gråwe, 2010; Kingdon & Turkington 2005). We will offer a brief summary showing how CBTp provides a technique to bring “thing presentations” back within the boundary of the self. Three fundamental models guide CBTp.

#### The Continuum Model (CM)

The CBTp approach assumes that psychosis lies along a continuum with ordinary mental life. For example, a continuum of beliefs exists in the general population. A substantial portion of the general public not otherwise considered mentally ill believes in thought transference, ghosts, voodoo, and the reality of the Devil, and does not believe in evolution (Kingdon & Turkington, 1994). A continuum of perceptions exists as well. Five percent of the general public not otherwise diagnosed as mentally ill hear voices (van Os, Hanssen, Bijl, & Ravelli 2000). The continuum translates to CBTp technique in the concept of “normalizing” psychotic symptoms. The CBTp therapist suggests to the patient that analogies to psychosis exist in everyone’s mental life, including that of the therapist. For example, the therapist might reveal he sometimes hears someone calling his name when no one is present, linking this hallucination of everyday life to the patient’s voice hearing experiences.

“Normalizing” psychosis and self-disclosure contrast sharply with the therapist’s neutrality in PP, which aims to keep a therapeutic distance. “Normalizing” psychotic symptoms places the therapeutic alliance on a more equal footing. “Normalizing” has the practical impact of significantly reducing the stigma of the mental illness label, which opens the possibility of a good faith conversation. Instead of telling the patient, in effect, “You have schizophrenia and I don’t”, the therapist is saying, “We all have a bit of what you have”. In psychological terms, CBTp constructs a new kind of therapeutic neutrality based not on the therapist as a blank screen open to the patient’s transference, but neutrality based on a common humanity along a continuum of mental life shared by therapist and patient. The CBTp therapist is encouraged to be informal, familiar, and cautiously self-disclosing, more real than would be the case in
PP. It should be said, despite clear differences in technique, psychoanalytic object relations theory assumes a continuum between the primitive splitting and projection seen in psychosis and similar mental processes operating in non-psychotic individuals in daily life.

**The Stress Vulnerability Model (SVM)**

The SVM is an open model which maintains that psychosis results from a $3 \times 3$ interaction of multiple elements, in which a biological, psychological, or social stressor interacts with a biological, psychological, or social vulnerability, leading to psychosis. In this model, a person with a high genetic vulnerability might become ill with the stresses of ordinary life (Zubin & Spring, 1977). A person with no biological vulnerability might become ill in response to a traumatic stress, like combat, bullying, or sexual abuse (Read & Ross, 2003). The SVM is readily grasped by most patients, and helps the patient to begin thinking about the interface between external events and the patient’s mind. Tienari et al. (2004) provide evidence for the SVM in an adoption study. Adoptees with a high genetic vulnerability to psychosis had a 1.5% incidence of schizophrenia (slightly higher than the 1% incidence in the general population) when raised in a healthy family environment. Adoptees with the same high genetic vulnerability have a 13% incidence of schizophrenia when raised in a disturbed family environment.

**The A-B-C Model**

The third model used in CBTp is the so-called A-B-C Model, (Chadwick, Birchwood & Trower, 1996), also an idea easily grasped by most patients. In this model, the “A” is an activating event, “B” a belief about that event, and “C” the emotional or behavioral consequence of this belief. The CBTp therapist attempts to show the psychotic patient that his distress about the activating event “A” results not just from the event per se, but is mediated by his beliefs about the meaning and personal significance of the event. For example, a patient who hears a voice saying “Take care!” (“A”) might find the voice more or less distressing depending upon whether he believes the voice is expressing a threat or a concern (“B”). The same glance from a stranger (“A”) might be interpreted as positive curiosity or a prelude to harm, depending upon the patient’s belief about the meaning of “A”. The therapist might say, “If your beliefs about the meaning of your experiences are correct, your distress is understandable. If there is another explanation for your experiences, some of your suffering may be needless. It is in your own self-interest to examine your beliefs and alternate explanations closely to see if there is any other point of view. Let’s investigate together and see what we find.”

Unlike the PP clinician, who positions himself as an interpreter of what the patient cannot see (the patient’s unconscious), the CBTp therapist positions himself to investigate conscious experiences of which the patient is well aware. The therapist joins with the patient as a research collaborator in a scientific examination of the ‘thing presentations’ of his psychic life. In psychoanalytic terms, CBTp provides a massive reinforcement of the observing ego in a carefully orchestrated progression of steps, and a special toolbox of techniques, in which Watson and Crick examine data, sitting side by side in the lab, in contrast to Freud interpreting Dora’s unconscious from behind the couch (Freud, 1905).
A typical CBTp for psychosis treatment might proceed as follows.

1. **Engagement.** The therapist elicits the patient’s description of his distressing experiences, which may include delusions, hallucinations, and periods in the patient’s life where the patient felt the victim of persecutors (or the mental health establishment). The therapist attempts to align the treatment with the patient’s distress rather than a diagnostic categorization of the patient’s symptoms. Treatment goals are linked to reducing the patient’s distress. The CBTp therapist attempts to “normalize” anomalous experiences which can occur under conditions of great stress. Introducing the CM and the SVM allows patients to be honest without fear they are confessing to a stigmatizing label.

2. **Timeline.** The therapist takes a longitudinal history, marking significant events on a timeline, including the first occurrence of the psychosis. Recording this history in a linear fashion on a piece of paper begins to establish connections between precipitating events and distressing experiences in their visual proximity on the page, antecedent to establishing psychological connections as treatment progresses. This exercise is often the first time the patient has ever attempted to make sense of his life in other than a delusional fashion.

3. **Initial formulation.** The therapist develops an initial formulation of the factors leading to and sustaining the psychosis, and may offer a simple initial reformulation which places psychotic experiences in a personal context, using the SVM. This starts to reconnect delusional beliefs embedded in external “thing presentations” with internal mental events. An initial formulation might be as simple as, “You were under great stress after your mother died. If I understand you correctly, you began to hear voices shortly after she passed away.”

4. **Coping.** Without challenging the patient’s delusional beliefs, the therapist explores the patient’s attempts to cope with his circumstances, and offers additional coping strategies. This strengthens the therapeutic alliance, and shifts the locus of control toward the patient. The patient learns that while distressing experiences appear to arise outside the self, they may not be entirely outside the patient’s influence. The idea that other people have had similar experiences and have coped with them in a variety of ways shifts attention away from the patient’s private, self-referential world to include the patient in a larger community. Learning what others experience and how they cope forwards the investigational spirit of CBTp.

5. **A-B-C Model of psychotic experiences.** Therapist and patient undertake a collaborative investigation of the patient’s distressing experiences, beginning with the distress which follows the patient’s beliefs “C”, working backward to the “A”, and then the “B”. The therapist may start with a simple sequence unrelated to the patient’s core delusion to teach the patient the A-B-C Model before approaching the core “thing presentation” around which the psychosis has crystallized. In psychosis, the “A” and “B” are often fused. The patient’s belief about the meaning of an event is not considered separately from the event itself. The CBTp therapist attempts to separate activating event from belief so beliefs can be examined. For example, a patient reported that he saw many indications in his neighborhood that he was under police surveillance. Tracing the history of his belief, the patient explained that he had first gotten...
the idea about surveillance from seeing an object partially hidden by a curtain in a neighbor’s window. The delusion can now be parsed in A-B-C format. Seeing the object in the window is the “A”. Examining the evidence, the patient conceded he had never gotten a clear view of the object. His belief the object was a surveillance camera can now be seen as a conclusion drawn from the memory of an indistinct visual experience rather than a fact. It now becomes possible for the therapist to show the patient that his initial misinterpretation of the “A” in the window has been subsequently repeated numerous times, deepening his conviction he is under surveillance.

With the CBTp workshop open, the patient and therapist work as co-investigators, employing a variety of structured tools as they investigate alternate explanations of various “A”s that have led to “B”s, that lead to a distressing consequence “C”. These tools include, but are not limited to:

(a) Detailed peripheral questioning. “What precisely did you experience?”
(b) Agreeing to not rush to judgment. “Let’s see how our investigation turns out in the end.”
(c) Rating the value of evidence.
(d) Rating the likelihood of beliefs.
(e) Identifying cognitive biases, like jumping to conclusions and self-referential thinking.
(f) Reality testing experiments to challenge delusions.
(g) Informational handouts to increase real world knowledge.
(h) Additional coping techniques.
(i) Homework assignments.
(j) Inference chaining. “If that belief turned out to be false, what would that mean to you?”
(k) “Schema-based” interventions (overlaps with unconscious fantasy).

Challenge beliefs and re-formulate the personal narrative. Based on evidence gathered in the A-B-C Model, the therapist begins to gently challenge the patient’s beliefs, offering an alternate formulation to the patient’s delusional belief. In psychoanalytic terms, the therapist assists the patient in returning “thing presentations” of mental life from the outside world to within the boundary of the self. Figure 1 depicts this process. Once the psychotic symptom intrudes into consciousness as a perceived “thing presentation”, connections to the unconscious are threadbare. The SVM allows the patient and therapist to return the patient’s experience to within the self by offering alternative explanations. Four levels of reformulation are possible, each returning mental events more fully within the self.

Stress Vulnerability Reformulation (Figure 1, 1). Depending upon the capacities of the patient, this reformulation may be modest, returning experience only to the boundary between the self and the outside world. The patient comes to understand that distressing experiences are contingent upon events in the outside world, but nevertheless have an internal origin, i.e. they are triggered by stress. The therapist need not explain why a particular event is stressful, or why the psychotic symptom takes the particular form that it does. “So it appears you began hearing the voices when you were so worried you would lose your apartment you hardly sleep for days.” This level of reformulation is almost always possible.
(6.2) Cognitive Bias Reformulation (Figure 1, 2). This alternate explanation draws the reformulation more deeply within the boundary of the self, allowing the patient to examine the relationship between internal cognitions, beliefs, and outside events. The patient can be taught to recognize cognitive biases such as jumping to conclusions and self-referential thinking, which helps the patient to “catch it–check it–change it” – recognize a thought as possibly biased, examine it, and change it. “Your belief that people on the bus look at you in a critical way appears to be an example of that jumping to conclusions bias we discussed. As you said in our last session, ‘It isn’t always about me’.” This type of reformulation is frequently possible.

(6.3) Psychodynamic Interpretation (Figure 1, 3). This extends the reformulation to include emotional elements which unconsciously contribute to the construction of the psychotic symptom. If CBTp is successful in returning the “thing presentation” to the patient’s mind, the connection between the symptom and the unconscious can be reestablished and interpreted. “After you were sexually abused you believed you weren’t worth very much. We have discovered through our investigation that the critical voices who say you are worthless are not all powerful authorities as you once believed, but a way you experience your own self-critical thoughts. When you were under the influence of the negative voices it was hard for you to see your positive qualities. You have begun to rebuild your life now. You have started your journey to recovery.” This level of reformulation is sometimes possible late in the initial phase of treatment when the “thing presentation” has been returned to the self. Instead of a delusional narrative composed of a sequence of hyper salient self-referential external events, the patient develops a personal narrative grounded in his life history and linked to the psychological factors underlying the psychotic symptom.

(6.4) Bio-Psycho-Social Reformulation (Figure 1, 4). This reformulation of the delusion includes the full range of biological, psychological, and social dimensions of the person. “The stress of immigrating to this country combined with the genes in your family tree led to voices which gave expression to many of your worst anxieties and self doubts.” This level of formulation is sometimes possible late in treatment. See Garrett (2010) for a detailed description of the treatment of a patient who heard “voices” predicting people would die, where the treatment deepened to a full bio-psycho-social formulation which linked the “voices” to her grief over the loss of her marriage, her parents’ deaths, her own illness and mortality, and her beloved dog’s mounting infirmity.

(7) Maintenance and “Booster Sessions”. Some patient’s can generalize from the CBTp treatment and recognize future occurrences of psychotic symptoms with minimal assistance from the therapist, while some require the therapist’s help in periodically examining new experiences. Once the patient has learned the A-B-C model and successfully applied it to past symptoms, it is easier to apply it to recurrent symptoms.
The essential place of psychodynamics

In addition to interpreting the psychological meaning of core psychotic symptoms in a reformulation of the patient’s experience, a psychodynamic perspective provides tact and timing to CBTp interventions throughout treatment. Consider an example of the intertwining of CBT technique with a psychodynamic listening ear. A psychotic man was abused as a child. His mother frequently used intravenous heroin in front of him. After his mother’s death he kept her clothing and the glass syringe she used to inject heroin. On occasion he would hear his dead mother’s voice and see her in his apartment. He would then dress up in her clothing and look at himself in the mirror, idealizing his and her appearance. “The only time I feel good is when I dress like her. Then I feel beautiful.” At times he would disrobe, stab himself in the arms and legs with his mother’s syringe, withdrawing blood, spraying it on his body, at times re-injecting it into his urethra. He experienced a decrease in the frequency but not an end to these episodes after treatment with medication. After several CBTp sessions focused on ways to cope with the voice without harming himself, the patient brought his mother’s syringe to the therapist in a plastic bag. He said, “I want you to throw this away.” From a psychoanalytic object relations view, when he dresses in his mother’s clothing his mental representation of himself merges with an idealized mental representation of a “beautiful” loving mother he never had. The syringe is a precious amulet used in a ritual of reunion with his mother, full of longing, rage and self-destruction. The therapist said, “This syringe was one of your mother’s possessions. It has been a
reminder of her for many years. I will take it and throw the needle away, but I will hold on to the syringe until we can be sure you are ready to let it go.” In the next session the patient reported second thoughts about surrendering the syringe, but in the end said he wanted the therapist to dispose of it. A psychodynamic understanding of the conflicted meaning of the syringe led the therapist to proceed cautiously, and to prepare a replacement. The therapist asked the patient if there were any positive memories of his mother he might substitute for the syringe. He said there was one. When he was 10 years old his mother bought him a microscope for Christmas. He brought the microscope to the next session, where the patient and therapist rehearsed this positive memory of his mother (Gaag & Korrelboom, 2010).

Once CBTp has returned “thing presentations” to the self, is the therapist’s work complete? Only if the therapist is not positioned for the long haul. Even when time-limited CBTp has been relatively successful, patients require ongoing care. PP sets a treatment frame and prepares the therapist intellectually and emotionally for the long haul. In this next phase of treatment psychodynamic skills play a central role. PP offers an arena in which the patient’s self can be nurtured over time (Lysaker & Lysaker, 2008). In a sequence repeated over and over, session after session, the psychodynamic therapist puts into words what the patient is thinking and feeling, in this way bearing empathic witness to the patient’s existence as a person. “I see you!” is the background refrain. Consider a brief example of this bearing witness. A woman with two teenage children had a psychotic episode after discovering her husband’s infidelity. She came to believe that her pastor was in love with her, and that God intended they marry. She and her family were told that she had “schizophrenia” and “erotomania”. A course of CBTp readily convinced her that her belief about the pastor was likely mistaken, but there was one thing she remained sure of. “I do not have schizophrenia!” Her husband had used the “schizophrenia” label to turn her children against her and argue for sole custody. Whenever she said or did anything contrary to his wishes, he labeled her self-assertion a symptom of “schizophrenia”. Her diagnosis had become an instrument of soul murder and she was prepared to resist this label at any cost to preserve some vestige of self-esteem. When the therapist put what she was feeling into simple words, she wept, expressing how grateful she felt to be understood. PP is composed of an accumulation of countless moments such as this between patient and therapist. By providing a holding environment where the patient can clarify thoughts and feelings, the therapist hopes to help the patient become a more functional, individuated person. Just as CBTp offers specific tools, the psychodynamic approach offers special tools to accomplish the goals of this phase of treatment (Lotterman, 1996). Without the exploration of thoughts and feelings which PP provides, CBTp alone risks leaving the patient in a mental world with less cognitive bias, but unrealized possibilities for emotional growth. A final proviso. While long-term relationships with psychotic patients are undoubtedly of great value, as noted above, the results of treatment may be limited if the patient remains locked in the thrall of “thing presentations” which block access to the patient’s inner life.

Conclusion
A psychodynamic approach does not provide sufficient technical means to return “thing presentations” to the realm of thought and feeling, where symptoms are amendable to psychodynamic interpretation. CBTp provides this technique. Psychodynamic therapists who learn CBTp will gain essential tools to accomplish this task, and CBTp
therapists who familiarize themselves with psychoanalytic ideas will gain tact, timing, and strengthen their work with patients in the initial and extended phase of treatment. There is room at the table for all, where each tradition has much of value to contribute.

References


