EARLY AND SUSTAINED DYNAMIC INTERVENTION IN SCHIZOPHRENIA

A short version of the Danish National Schizophrenia project (DNS) manual for psychodynamic individual psychotherapy with persons in states of schizophrenia

Bent Rosenbaum, MD and Lars Thorgaard, MD

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PREFACE

The Danish National Schizophrenia project (DNS) is a multicentre investigation which began October 1997. It includes patients, consecutively referred over a two year period, with a first-episode psychosis of ICD-10, F-2 type. Sixteen centres participate and the patients are allocated to three kinds of treatment:

1) ‘Supportive psychodynamic psychotherapy as a supplement to treatment as usual’,
2) ‘Integrated, assertive, psychosocial and educational treatment programme’, and
3) ‘Treatment as usual’.

In order to manualise the supportive psychodynamic treatment we (Rosenbaum and Thorgaard) initiated in 1996, on the request of the Steering Committee of the Danish National Schizophrenia project, a detailed manual concerning early and sustained intervention in schizophrenia. It consisted of two parts: a theoretical part and a clinical-technical part, and these were published in two volumes in Danish. The present work is an extraction of the clinical-technical part of the manual. It is slightly revised from the original version, mainly by clarifying vague sentences and viewpoints according to what was carried forward and spoken about in supervision sessions. It attempts to be concise concrete, and it is pruned of theoretical arguments and discussions.

Bent Rosenbaum & Lars Thorgaard
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Psychotherapeutic Section E
THE USE OF A MANUAL

Manual derives its meaning from the Latin ‘manus’ (hand). In its simple form, a manual is a set of directions, or guidelines, from which both the therapist and researcher may proceed in their thinking and doing. It contains guidance about what the psychosis psychotherapist may think in relation to the psychotic patient and directions as to what the therapist should avoid doing. The most important tool of the psychotherapist is his ability to listen to subjectively informed accounts and allow himself to experience and reflect on these without being overwhelmed and dominated by such impressions and sensations. The therapist listens and understands (something) and intervenes according to his understanding, e.g. by seeking clarifications or by listening further.

The manual for psychosis psychotherapy provides certain guidelines for a therapeutic stance and behaviour which, according to our present knowledge, may be useful and conducive to the patient and to the course of treatment. Each therapist will understand these guidelines with a subjective touch that is related to his personality structure, his experience and his expressive style. It is the therapist’s subjective reworking of what is heard and said in the therapy that increases the chance of objectifying the material and so make it accessible to mutual exploration between patient and therapist. It is therefore important to exercise and test the individual elements of the manual so that the content of the manual consolidates itself in the mind of the therapist and becomes part of his general therapeutic framework.

A manual for psychotherapy contains a number of theoretical and technical concepts that are necessary in order to understand what happens in the many interactions between therapist and patient. Theoretical concepts are always difficult to understand fully when applied in practice. And with the myriad interactions that take place in the therapeutic space, a manual can only lay out rough and general guidelines. Discussions of the manual are hence necessary with a view to providing greater clarity regarding the concepts that form a foundation of the attitude and technique in undertaking dynamic psychotherapy especially with people suffering from schizophrenia. The manual should thus contribute to increasing awareness in the therapist’s mind; awareness of the therapist’s impressions and sensations, awareness of thoughts coming to mind through many interactions, and development in the therapist’s conceptual understanding of what takes place in the therapy.

This manual is written on the assumption that it is primarily psychiatrists and psychologists who may be the psychotherapists, although we are aware that some treatment units draw on other specialist trained staff and/or nurses in their treatment programmes.

The purpose of the present manual for psychotherapeutic treatment is for it to be adapted to the psychiatric treatment that already exists within community psychiatry or hospital settings. Psychotherapeutic intervention that is

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1 A manual is also a research tool and in principle contains a set of directions as to what the researcher into psychosis therapy may focus on when he observes, describes, and assesses the processes and results of the therapy. In the following, we only focus on the therapist. The researcher will have to seek directions from elsewhere.

2 Claustrum phenomena are concerned with the patient’s ability to penetrate into the other’s mental universe (claustrophilia) and then feel caught up by and enclosed within the other’s interior (claustrophobia). Different phenomenologies apply to the existence within this maternal space, but a common feature is the experience of distortion of interpersonal processes: generosity becomes offence, receptiveness becomes cajoling, mutuality becomes collusion, understanding becomes spying for secrets, wisdom becomes information, help becomes control or persecution. The most serious psychopathology is
to supplement 'treatment as usual' should be offered and possibly initiated immediately after general psychiatric treatment has begun, that is, with the patient's first admission to psychiatric hospital or in connection with the first referral and initiation of treatment within community psychiatry settings.

**FRAMEWORK OF THE PSYCHOTHERAPY**

The individual dynamic psychotherapy which is provided by some centres in the DNS involves 2 years of psychotherapy once a week (70-80 sessions). The individual psychotherapy is a supplement to 'treatment as usual'. As a consequence there is a division between on the one side the responsibility for the organisation of daily psychiatric treatment with all its different elements, and on the other side responsibility for the psychotherapy. This in itself may raise problems and a number of considerations regarding this ought to be thought through before beginning the therapy. Experience shows that the therapist often neglects or underestimates the practical and technical framework necessary for his role and function as a therapist. Some basic factors and questions which appear during the beginning phase of the psychotherapy, or even before, shall be mentioned briefly here.

1. **Where can the therapy take place?**
   - Do I have my own office at my disposal? Or do I have another room consistently available at the time when the therapy is scheduled to take place?

2. **How often and how long am I to speak with my patient?**
   - Shall it be ½ hour, or ¾ of an hour? 1, 2 or 3 times weekly?
   - Can or should I, during periods when the patient may need it, increase the frequency or duration of the psychotherapy? What would trigger more frequent sessions? (If intensified intervention in case of psychotic exacerbation is an option, we suggest that this is only communicated to the patient when the need arises).

3. **What determines the length of the therapy?**
   - What is the length of the therapy as determined by the project?
   - What may further determine the length of the therapy: distinct improvement in conditions and wish for termination, drop-out, moving out of the area?? How should I deal with these challenges and possibilities? How should I act if the patient fails to appear at the treatment sessions; what should my active contribution then consist of (phone, write, remain passive)?

4. **Can I get regular supervision, or get supervision when necessary?**
   - If supervision groups have not been set up, why is that so, and how can this be remedied?

5. **Can and should I relieve myself from the administrative part of the treatment (including medication)?**
   - Have fixed agreements been made about the prescription and administration of medication? And what about psychotherapy during possible admission? What about the exchange of
information between ward and therapist? Has the patient been informed and consented to these agreements?

6. Are my superiors in agreement with the treatment and do they actively support the psychotherapy?
In research projects, there are always unrealistic expectations connected with the therapy. What can I expect by way of resistance and demands: - from my colleagues, staff and from the patient - and how may impact on the treatment?

The guidelines in the DNS project:

1. The psychotherapy shall take place in the same room every week. If the patient has a relapse and for this reason cannot leave the unit, the weekly psychotherapy session can take place in the unit.
2. The sessions shall in principle last 45 minutes but if the patient for different reasons can’t tolerate this length of time, then the therapist after due reflections shall act in a flexible manner. Both active psychotic symptoms and phases in which the patient feels much progress, but thus also experiences his problems as heavy burdens, can be reasons for more frequent sessions. No change of frequency can be allowed without consulting the supervisor.
3. The individual therapy has a fixed time limit of 2 years. The time frame is explained to the patient at the beginning of the therapy.
4. The project provides all therapists with the possibility of regular supervision.
5. The therapist shall abstain from having the role and function of the psychiatrist in charge of the patient’s treatment.
6. Questions involving possible ambitions, envy, devaluation and idealisation, and other emotions residing either in the therapist or in the expected attitudes of colleagues, staff, superiors, etc. are worth considering in the initial sessions of supervision. Sometimes the first supervision takes place before the first session with the patient.

AIMS OF THE PSYCHOTHERAPY

Within the DNS, the individual psychotherapy has the following overall aims of treatment:

1) **Focus on the fact of having become ill.** It is an extremely traumatic event to become psychotic. Experiencing that ‘the mind is falling apart’ and that ‘reality changes meaning’ as well as “I cannot do the sort of things that I managed before”, or “I do not feel connected to the world as before”, etc. may be compared with experiencing a natural catastrophe. The therapist must keep this fact in mind and recognise that lack of sense of illness and recognition of illness is both an effect of the illness and a defence against this traumatic experience.
Denying being ill and not being able to face having this problem is thus, in more than one sense, part of the illness and may lead to further deterioration in the course of life. The patient must be helped to recognise the dynamics of their illness. An understanding of the origin and development of symptoms and the subsequent break-down must be established. This is a precondition for the feeling of a need for support and help and thus a precondition for staying in therapy.

It is an aim to work through the anxiety of potential new break-down. This anxiety is the expression of recognition of illness and is an ally in the therapeutic process. It is furthermore an aim to work through the aggressive and fearful mistrust of others.

2) **Focus on healthy functioning.** The therapist must help and support the patient to recover greater emotional contact with the possibilities of his way of living in the presence of reality. Often the patient does not understand what has happened to his previous ways of experiencing life, and why it happened. Intense defence mechanisms will come into force to deny the significance of past, present and future events. It is an aim of therapy to work with these defence mechanisms so that they can be discovered by the patient as imposing false conditions inhibiting his view on what he really is able to do, making him adapt to a mental condition that restricts and limits his true potential. The illness imprisons him and bars him from participation.

To work with the resources of the patient demands a focus on what it would require of the person to resume studies or work, move back to his own home, remain alone, or move in with others, etc. What possibilities and constraints does the patient see as to resuming dreams for a future life and a life with new perspectives?

3) It is also an aim of therapy to **develop a responsible and autonomous stance towards medication** (including “self-medication” and or abuse). Maintenance of medication in sufficiently low doses is an important focus. The therapy must raise awareness of those internal and external factors that increase the patient's anxiety and feelings of needing more medication. Equally important is an awareness of those factors that may lead to a decrease in that need. The stance on medication must be one of collaboration. A paternalistic stance is only to be adopted when it is judged dynamically appropriate or absolutely necessary.

4) **Focus on re-orientation in connection with actual loss or changes in social, psycho-social and interpersonal conditions.** To dare giving up habitual thoughts about oneself and others, thoughts that have had a negative influence on the patient’s life, involves undertaking the work of mourning. This may have considerable influence on the patient’s overall mental
functioning and may orientate the patient towards more general and realistic aims in life and so, over a longer period of time, give the patient a higher degree of self-esteem. Development and recovery of social and interpersonal skills are at a prime. This may involve participating actively in the concurrent milieu therapy at the ward where the patient may be admitted or in the social-psychiatric programmes where the patient may be enrolled, etc.

5) **Focus on developing the capacity for a therapeutic alliance during the whole course of therapy.** Establishing a stable, basic trust and understanding in working with oneself requires time. This capacity must ideally be transferred into future social relations outside of the framework of therapy. In the cases where the therapy has to be terminated prematurely, this capacity can be utilised to consider entering another therapy (at a later stage) with a view to continuing the work on the problems that were not resolved during the first psychotherapeutic treatment.

The psychotherapy thus stresses these kind of metaphors: ‘getting back on the track’, 'nourishing the appetite for life', 'gathering the scattered thoughts and feelings and working your way forward'. At the end of the therapy, future dealings with reality should hopefully take place without the person losing his social and subjective moorings or the sense of meaning in life. In many cases, therapy requires a working through of basic psychic conflicts, in addition to the reworking of actual losses of general aims in life and a feeling of being incompetent in life.

**THE PHASE IMMEDIATELY PRECEDING THE BEGINNING OF PSYCHOTHERAPY**

**The relationship between psychotherapist and ward**

The patient’s way to psychiatric treatment is either referral to outpatient treatment in the community psychiatric unit or admission to inpatient treatment in a hospital unit. The latter category creates the greatest problems for the initial phase of the psychotherapy, primarily because many parties are involved in the treatment and may have different objectives. Conscious as well as unconscious organisational forces may pull in different directions which may confuse and misguide the patient and the therapist at the beginning of the treatment.

During the initial phase, **clear information must be given to the patient:**

- concerning the purpose of treatment. The therapist must before the first session “rehearse” some phrases that may be considered useful, clear and relevant; e.g.: The purpose of psychotherapy is to help you overcome difficult situations that you present life circumstances have confronted you with. By learning from how you experience yourself as a person, and from your experiences of present and former relationships
we shall together try to understand how your symptoms and your present
difficulties bar you from getting on with your life."
• concerning the initiation of the therapy. The therapist must inform the
patient accurately about the time for starting the psychotherapy. Do not
use phrases like "the therapy will start after you have spent some time in
the unit";
• concerning location and setting (see points above made in the section on
‘Framework of the Psychotherapy’).

It needs to be decided who conveys this information to the patient, and how
it should be worded. There should be clear co-ordinated and consistent
information involving the referrer, the ward, any others involved and the
psychotherapist. All explanations from these parties must be co-ordinated and
understood as being a shared common approach with a clear idea of what is
expected as a plan for treatment. Finally one should consider, in collaboration
with you colleagues, how you are going to approach the patient if you have to
deal with a potentially silent, autistic, hallucinated, suicidal, or violent patient.

Keywords when addressing the patient

Getting better
Psychotherapy is an aid for you to get as well as possible. That is
to say, to function as well as possible with others and function well
when you are alone.
Changes never come by themselves. Being in psychotherapy
means that you will have to make an active effort to create
changes.

Understanding more
In psychotherapy you may talk about the problems that are
important right now and about the problems which you think may
arise in the future. You are also free to speak of difficulties you
have had before.
During therapy you may use me to try to understand the
experiences you have which may sometimes feel difficult to
understand. It is important to understand the relationships you have
with other people so that it becomes easier to understand why you
became ill and how you can get well again.

Staying in treatment
It is important to stay in treatment as long as necessary. Often a
person with psychosis may find that treatment "just makes it all
worse". The same may be the experience regarding medication.
But the psychotherapy will try to help you through these 'crises'.
Just when it feels worst, it is important to have a therapist to talk to
about the possibilities that are still there to get on with yourself and
your life. The psychotherapy therefore intends to support you.

The collaboration between the therapist and the ward/unit
The psychotherapist may have certain preferences as to how the patient
should be informed about possible concurrent treatment modalities (medication,
family support, unit responsibility etc.), and how these treatment modalities may
relate to the psychotherapy. Collaboration with the ward has to be formalised in this regard!

It must be made clear for the patient how much material from the ward the therapist is to be familiar with. One or two treatment conferences or meetings prior to the start of psychotherapy may be convened. At this meeting:

a) therapist and staff share information about the patient (history of illness, life story, interpersonal relations),

b) some initial hypotheses are generated regarding the future treatment, and

c) possible themes and metaphors concerning the treatment are outlined.

**Psychotherapist and supervisor**

When the therapist has been informed about the patient, then supervisor and therapist may have one or two meetings before the therapist meets the patient for the first session. In the meeting with the supervisor the therapist sets forth his reflections and hypotheses - that is, assumptions about the patient’s current conflicts and coping strategies and an understanding of what led to the psychotic breakdown. These assumptions - which are at the same time fantasies and possible hypotheses - are worked through in collaboration between therapist and supervisor. A time is set for beginning the treatment as well as the first hour of supervision. This should preferably be between the 1st and 2nd session with the patient, with a view to revising the assumptions initially generated.

**Style and technique of the psychotherapist**

Every psychotherapist's ways of being in relation to his patients is likely to be very different. Partly, therapists have different personality structures. Partly, therapists use themselves as persons in very different ways (although they attempt preserving a neutral stance): some vigorously engage their own person (gesturing, mimic, tone of voice, humour, use of own experiences), whereas for others neutrality signifies non-personal involvement. Also we all have very different experiential backgrounds, and finally the counter-transference will in many cases determine how each therapist is going to react.

It is not easy and probably not useful either, to alter your therapeutic style radically, but it may still be appropriate for the therapist to bear the following in mind:

- The psychotherapy must be a dialogue that has a *structure*, and this structure is supposed to counter-balance dissolution and break-down. The dialogue should be natural without having the form of ordinary conversation. *Ideas are conveyed by the patient’s narrative stream of consciousness, whereas the therapist structures his thoughts as they appear during the session.*

- The contents of the therapy should be focused and with clear reference to what issues are being talked about, although all therapists know that often many things are talked about at the same time, and that utterances always carries the possibilities of harbouring hidden meaning.

- Persons in states of schizophrenia have difficulties being realistic in planning and in focusing their intentions, and they are helped by *practicing what they discover in the course of therapy*. Words and fantasies are not sufficient means for “learning-from-experience”, and giving the patient possibilities of testing his/her thinking with the right
timing is necessary in an attempt to change the patient's behaviours and ways of relating to others.

- Dynamic psychotherapy always focuses on the development of the self, and this takes place through learning from the transference - whether it appears as transferences outside or within the therapeutic space.
- The therapist should not remain emotionally neutral, but authentically empathic with what the patient says and in what the therapist chooses to formulate in his interventions.

PHASES IN THE THERAPY AND PHASE-RELATED PROBLEMS

THE INITIAL SESSIONS (session 1 to 6)

You should consider making a video recording of the first encounter between patient and therapist. You should explain to the patient that this is done in order to ensure the best possible treatment, but especially it is done so that the recording may be watched by a small group of colleagues who, on the basis of the recording, will discuss how the patient may best be helped and supported. You may also suggest to the patient that you and he/she perhaps may watch the tape together and learn from it. It should be emphasised that the recording is not meant for teaching or any other public showing. The patient must know that he or she may at any time demand that the recording be erased. Often one may reach a mutually useful agreement by suggesting that the tape be erased when the therapy has ended.

The first sessions with the patient have the purpose of partly creating the basis for a treatment alliance and partly gaining knowledge about the patient’s mental life. These two purposes often go hand in hand, but they may clash with each other. During the initial sessions, you should attempt to extract as many psycho-social facts as possible.

The psycho-social facts differ from the purely social facts. The latter include: employment, housing, education, place of living, etc., and while these are important to talk about, they become more relevant later on in the course of treatment. The psycho-social facts that the therapist needs to establish at the outset lie closer to the notion of significant life events and external object relations: the patient’s images of himself and of others, and the patient’s experiences of interpersonal relationships.

In the assessment interview the therapist is thus interested in the emotional meaning of daily life events, interactions and interpersonal relationships.

During the initial session the therapist may want to be informed about the following:

- The patient’s perception of himself as a person. The therapist may ask: “Could you tell me a little about yourself in such a way that I get a picture of you as the person you are –how you feel about yourself and the thoughts you have about being you?”
- The patient’s experience of significant others (run through the line systematically): mother, father, siblings, friends (long-standing friendships), fellow students and work mates, spouse, children. The therapist may say:
“Other people always evoke various feelings. Could you tell me a bit about your relationship to x – what you think and feel about x, and what do you think x thinks and feels about you?”

- The patient’s experience of those themes, conflicts or problems it is most important to work on during therapy. “What do you think is the most prominent problem right now… and what do you think our work together is mainly going to be about?”

These questions are introduced at a stage in the conversation when they seem most natural. It is important that the therapist not merely obtains information about the presence of a feeling e.g. anxiety, grief, discomfort, chaos, but also gets interpersonal relations joined to the description of the prevalent emotion. The therapist must find out in which situation the feeling arises and develops. Who was or could be present? Was there anyone who did anything to someone else? Is the patient afraid that someone gets to know too much of what is going on in the patient? And so on.

Apart from external object relations, it is important to speak in depth about:
1) the psychotic episode that has recently developed, or occurred out of a longer period of incipient identity-disturbing experiences;
2) factors that have led to the admission or referral for treatment, that is, questions such as:
   - “Tell me about what you find to be the most important problem?”
   - “From where do you think the problem stems?”
   - “Who or what do you think could help solve the problem?”
   - “What situation might worsen the problem?”
   - “Do you recognise the problem from previous experience?”

During the first session, it is necessary that the therapist outlines the time-frame of the therapy. To some patients a year or two seems a short period, while other patients think that a year is a very long time and that everything should be over and done within a fortnight without any particular effort on the part of the patient. Nonetheless it is important to inform the patient that the treatment of his illness or disease is a long process, and that the attempt to achieve progress and improvement begins right here and now.

The conclusion of the first session might very well consist in underscoring that now something new is beginning, a process where both patient and psychotherapist must contribute to getting the patient attuned to his own life.

What may the patient be expected to know about psychotherapy?

The patient must be expected to have heard the word psychotherapy and perhaps also to have had a minimal explanation of what it implies ‘to be in therapy’. Yet the therapist must assume that to the patient ‘being in therapy’ is something rather vague. The patient must therefore be informed as to the purpose of the therapy. The wording, which should come towards the end of the session, might be

“Now that we have talked about the possibility of you getting help with your problems by means of psychotherapy, you may want to know something more about what this entails. I’m going to tell you something about the purpose of our meetings” (it is important that this message concerning the purpose is conveyed in a “natural” way, and with respect to the patient’s
nonverbal and verbal signals that he follows the therapist's line of explanations).

It is important to explore how the patient understands the explanations and ideas given by the psychotherapist, e.g. “What do you think about what I just said to you”. It could be specified by the therapist that the patient’s pathology partly consists in difficulties in having an emotional contact with others, or in having lost confidence in others, and having withdrawn socially from others in order to protect oneself. By saying this, the therapist indicates that he is aware of the depth of the problems, and that the therapy is about learning to recover confidence and contact in relation to others and particularly in relation to himself.

Also you should tell the patient that he has to be prepared to do some work in order to get well, but that he can rely on the therapist being prepared to help and support him during the following years. An emphasis of shared responsibility is important and a consensus needs to be reached between the patient’s and the therapist’s expectations regarding the goals and initial focus of the psychotherapy.

If the patient asks questions about the nature and purpose and other conditions of the meetings, then it is important to answer naturally in the conversation. The natural attitude in the conversation comes before the adherence to rules of technique, e.g. silence with a view to getting to the patient to say more, or a question as to why it is important for the patient to know this right now (although the therapist should, in his own mind, always consider what may lie behind the patient’s question besides wanting to be informed about factual matters). If the therapist for some reason wants to postpone answering the question till later in the session, the reason for this must be made explicit:

“I think your question is very relevant, and I have also noted the question for today. I would prefer to wait with answering the question till the end of the session – I hope that's okay?”

Needless to say, it is then fatal to forget to take up that question!

**Concluding the initial sessions**

When the initial sessions are due to be brought to a close, the therapist should once more express empathy with the mental sufferings of the patient and at the same time emphasise that the patient does contain healthy resources which are to be included in the therapy:

“I can sense that it is very hard for you to think about the fact that you have become ill. In my experience, nothing is gained in the long run by trying to close your eyes to it. It is always more important to try to act in a healthy way, though you and I do recognise that along with your good health, there is also another side: the vulnerable side which we have to counter together. That is the purpose of the therapy. The best way of dealing with having become ill is to talk about the vulnerability here in therapy. This can make sense of what may at times be experienced as meaningless.”

An important area is the dynamic understanding of the inclination to distrust medication.
“It is understandable that you would rather be free of the feeling of being ill. You may, for instance, feel like quitting medication without telling me about it. You may think that the medication has no effect, and you might in secret try to convince yourself and me about that by stopping to take it. If such thoughts or feelings should arise, my suggestion is that you nevertheless resolve to tell me about the thoughts before you possibly act. We will then together try to make sense of them and so join our efforts in protecting you from working against your own possible progress.” … “Is that okay?”

In cases where the patient’s history contains information about other possible self-destructive elements e.g. consumption of cannabis, speed or other kinds of addiction (including alcohol), this should likewise be discussed with the patient as factors that might impede real progress.

When the initial sessions are nearing their end, it is important together with the patient to go through what the therapist has noted as the psycho-biographical and conflictual ‘highlights’ that may later serve as a focus. This will give the therapist a sense of what he and the patient ‘agree’ and ‘disagree’ about (consensus). It will also give the patient a structure for how he may proceed with the next step in the therapy (focus). And this will make the patient feel that the therapist has been listening to the words and thoughts that have been exchanged, and that he has taken them seriously.

The therapist’s description of ‘highlights’ may well be comprehensive, if the patient is able to grasp it, but it has to be crystal clear. The intervention that expresses the therapist’s understanding is given in ‘stages’, allowing for space and dialogue.

POINTS TO REMEMBER:
- Agreements regarding time, place, and frequency
- Agreements on whether the patient is to be helped to the sessions from the staff of the ward
- Agreements on possible safety measures (suicide risk, violence)
- Agreements on failure to appear for a session (concerns both patient and therapist); to phone, to write, to contact the patient through others?
- Agreements with the patient about what information may be exchanged between therapist and others involved in the patients care and treatment.

Following the initial sessions, the psychotherapist reflects and formulates a set of hypotheses. These hypotheses form part of the therapist’s considerations regarding:
- Formulating the patient’s history of life and illness. This includes hypotheses about the dynamics of the patient’s current life problems and the associated pathological processes of grief.
- The presence of suicidal and/or violent thoughts and impulses, currently and in the course of the illness. It is important to give the patient a clear sense of you as a therapist having an eye for suicidal impulses, or self-destructiveness and violent behaviour, and that you are prepared to help the patient avoid them being carried out.
- The degree of awareness of illness and sense of illness. The patient must know that the therapist regards mental illness as a condition for which treatment is needed. The therapist should expect to be challenged
on this and should have facilitating answers ready. In these cases, it may be important to formulate a hypothesis as to why such decompensation occurs precisely now. Phrase this in terms of open questions: “Is it conceivable that…?” or “Might what is happening now be seen as…?”

- The possibilities of, and the obstacles against, creating a therapeutic alliance with the patient and of stimulating his hope in getting better, i.e. becoming more himself with a more natural self-understanding (less mistrust, higher self-esteem, less anxious).

All the above mentioned points are important considerations to reflect on using supervision.

**SUPERVISION FOLLOWING THE ASSESSMENT INTERVIEWS**

It is useful if the therapist is able to present his observations in supervision either during or shortly after the initial sessions. Whilst supervision does not have the character of control, it will be a help for the therapist if the supervisor would assist in ensuring that the above themes are touched upon in the initial sessions (to the extent that this has been possible).

In addition the supervisor may assist in generating hypotheses and metaphors which may possibly be activated in the course of the therapy.

**THE INITIAL PHASE**

During the initial phase, the patient is preoccupied with what staff have done to help him, or he is preoccupied with what the treatment or the persons in his surroundings prevent him from doing. Medication, detention against his will, disturbing fellow patients, and disagreement between the viewpoints of patient, family and staff, all together make the patient’s experience of the situation chaotic. What is clear and coherent to the staff is not necessarily so to the patient. He may feel treated by an institution rather than by human beings, and from his point of view there may be a lack of logic and coherence in the treatment.

What is important about this phase is that as much material as possible from the initial sessions is crystallised into current and future working themes. The therapist must relate to what the patient brings and bring some possible ‘reason to the madness’: “You tell me that…, could this mean that…?”

Where it is felt possible, the material should be connected to the observations that the therapist and the patient made together in the previous sessions:

“You tell me that…, and that reminds me that you have previously told me that…, so that when you encounter this as a problem once more, it might mean that…?”, “What might you do differently next time you get into the same situation?”

In the description of these situations of conflict, the therapist may sense which transference roles he may come to assume.

Agreement and disagreement about what has been said, what it means and how it may be used, are key elements during the first phase of the therapy. Diverging viewpoints between patient and therapist should never develop into entrenched positions, offensive-defensive fixations, or any other forms of polarization. The first task of the therapist is to structure the situation so that he
ensures that the patient listens to, and hopefully understands, not only his own, but also the therapist's viewpoints, and so aims for a shared foundation from which further accomplishments may emerge.

The therapist must, despite the patient's obvious signs of psychosis, trust in the existence of some normally functioning ego within the patient, and he must support this by appearing very simple, almost over-consistent in trying to pursue aims so that the patient's insight into himself is increased. The careful, slow, and detailed explanation to the patient may in the initial phase be crucial to reducing the patient's possible anxiety and distrust.

One overall aim is creating space for reflection and consensual validation. The patient is highly insecure as to whether the therapy space is a mentally secure space and will often find the therapy space to be full of traps - once you're in, you can't get out; once you've said something, this can used against you; once you've got too close to another person, you won't be able to get away again. Or he will find the communication unintelligible or open for attacks: vicious and hurtful remarks, cutting remarks, surprising rejections. The patient feels it necessary to guard himself against these traps and attacks. These and other experiences may be expressions of projective identification and claustrum phenomena (Meltzer, 1992).

The therapist must empathise with the fact that this is about defensive and adaptive ways of reacting. Inflated invulnerability and inaccessibility (megalomanic behaviour) or withdrawal is experienced as necessary despite their inappropriateness.

Persons in states of schizophrenia often find it difficult to express what they feel, have a hard time believing that the therapist understands that, and have difficulty believing that their thoughts may enter the consciousness of other people at all. Ordinary words such as 'talking together', 'relations', 'group', 'understanding', 'ending', 'looking forward to', 'mourning', etc. may hold totally different meanings to a patient in a schizophrenic state than they do to the therapist. The therapist may express an awareness of such discrepancies and may use his knowledge to explore what the words mean to the patient, so that gradually a shared communication may be created.

As a therapist, you will find that, at the beginning of the therapy, you may feel like having been sent to a remote island to make contact with fellow human beings situated on another island, far away. Just as the therapist feels that the islands approach each other, it turns out to be just a 'hallucination'. Harold Searles (1965) has called this phase 'The out-of-contact phase, Thomas Ogden (1980) calling the state of the initial phase 'The state of non-existence', while Kayton (1975) calls this phase 'The initial disorganisation'. Silvano Arieti (1974) terms it 'Establishment of relatedness', and Donald Meltzer (1967) is speaking of 'The gathering of transferences'. Others have probably found similar terms referring to the mind of the patient overwhelmed by fragments of thoughts, without a symbolic meaning anchored in the present communication or in a shared common sense world. And these terms point to the task of the therapist

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2 Claustrum phenomena are concerned with the patient’s ability to penetrate into the other’s mental universe (claustrophilia) and then feel caught up by and enclosed within the other’s interior (claustrophobia). Different phenomenologies apply to the existence within this maternal space, but a common feature is the experience of distortion of interpersonal processes: generosity becomes offence, receptiveness becomes cajoling, mutuality becomes collusion, understanding becomes spying for secrets, wisdom becomes information, help becomes control or persecution. The most serious psychopathology is attached to the corporeal space where the ordinary events of living lead to the experience of: persecution, attack, sadism, torture, control, anxiety about being eradicated of excommunicated, if the person fails to experience having full power and control over others and over his own situation.
who has to be open-minded, being able to contain both confusion, distortion and non-understanding, but also being honest to the patient as to telling him/her what he as therapist has heard and understood.

The therapist may feel the task to be like gathering a book where the pages are scattered all over the room. Suddenly there is something that looks like a theme, perhaps a whole story, but soon enough this story may be denied by the patient. “These are not my thoughts”, “It might be that way, but I don’t know”, or “I don’t want to talk about that, because then I get the symptoms”. But such statements must not prevent the therapist from doing his work.

The therapist will thus have to perform a lot of reverie work (Bion, 1967). Reverie is the opposite of dreaming yourself away from what is happening. The affects which the patient allows to be expressed and which are projected onto the therapist are for the therapist to try to make sense of; firstly for himself - through reverie – and later to pass on meaning to the patient. To make sense of something consists partly of showing the possible content of what is being said. The therapist may, for instance, conceive of various ‘reversals’ of what is being told, such as:
- changing passive into active,
- turning recipient into agent,
- letting one quality count for its opposite,
- confirming the negated,
- showing stability within diversity.

The therapist thereby may imagine that when the patient speaks of others then this may make sense within the patient’s own emotional life too. The therapist may then also open up the possibility that when an interpersonal difficulty is being addressed then this may also have significance within the framework of the therapist-patient relationship (transference).

The patient may begin to sense that similar situations taking place in different locations or at various times may contain elements with the same meaning, or same underlying structure. Or vice versa, that similar situations in different contexts may infer quite different meanings. This can be confusing to the patient, since the patient would prefer that there should be only one true sense of his words or thoughts, and that the right sense is the one that he, the patient, has chosen. Conflicting meanings are dangerous to the patient. Sense may, to the patient, be something that may only with difficulty be transposed from one situation to another. It is here that the ‘reverie function’ has its force. The therapist marks the possibility of utterances and statements having various meanings, implications and perspectives, and the patient gains confidence that the therapist does not destroy the sense of the thoughts which the patient has appropriated.

RULES OF THUMB:
- Always find the optimal closeness and distance regarding the patient.
- Don’t be too ambitious.
- Be aware of your possible pessimism. Seek realistic hope.
- Expect maximum autonomy from the patient, based on the given conditions.
- Work with here-and-now experiences and present events. Work empathically with the patient’s defensive and adaptive measures. Connect for instance symptoms with daily stress factors.
- Avoid the method of free association.
• Avoid the genetic analysis of transference, but keep it at the back of your mind as a map of here-and-now dynamics.
• Imagine the material of the session as if it were a dream. Emphasise the healing aspect of the material.
• Do not interpret the positive transference, since this will create anxiety of fusion and separation.
• Give "names" to the aggressive impulses of the negative transference. These can often be described as defences against loss, mourning and depression.
• Intervene using the patient's language. Avoid technical language. Speak briefly, accurately and simply, but not boringly.
• Explore whether the patient has understood the intervention by monitoring the quality of therapeutic rapport and consensus.
• Intervene with ‘suggestions’. “Might it be that…?”, “What do you think about the following viewpoint as a possible supplement to your own…?”
• Do not interpret dreams, but respond with interest to the dream and consider the patient’s feeling about the dream.
• Be aware of counter-transference processes.

The initial phase and supervision
The supervision may function as a reservoir for what the therapist ‘forgets’ or avoids during therapy. It also serves as a place for the creation of new fantasies and ideas. What you forget or avoid in therapy, as well as lack of fantasies and ideas, may be an expression of counter-transference. The supervision must not be experienced as moments of control and examination, but has to be a workshop for the creation of vigilance, curiosity and new ideas.

THE MIDDLE PHASE
Now 3-6 months have elapsed, and the process may take on at least four forms:

• Work is being done on one or several psychological problems, and though not all of the patient's symptoms have disappeared, the patient may feel attached to the therapy and to the experience of being helped.
• A creative therapeutic relation. Smaller or bigger steps are taken in the direction of the patient developing and representing the working themes from the initial phase.
• A destructive/difficult therapeutic relation where the patient is mentally absent or does not at all manage to work with the therapeutic material. The patient does not engage with his problems in the process of psychotherapy. The patient appears totally preoccupied by his symptoms or details, but no meaning seems to be gathering for the patient.
• An intermediate form which may be difficult, because it is static, e.g. the development of working themes feels stranded, likewise the transference, and the intensity of the conversation feels neutralised and stuck. However, the situation is good insofar as there are no catastrophes, and the hope of a more creative process is naturally preserved.

The middle phase is normally the phase when the difficulties of the therapy will increase. It is difficult as the therapist, to orientate oneself during
the middle phase. What has been said previously is repeated, and previously told stories or events (normally mentioned already in the assessment interviews) are taken up in old or new versions. The words of the therapist are perhaps neither valued, heard nor understood. The therapist’s personal style and defence mechanisms are being tested, and certain therapists may start to doubt that psychotherapy is right for the patient, or he might think that psychopharmacological treatment alone would do just as much good as psychotherapy.

Therapists who are disappointed – about the therapy not progressing in either the way or with the speed they had hoped – will invariably force the pace and rhythm of the therapy or say something to the patient about the lack of progress which will be so frustrating and disappointing to the patient that his condition will deteriorate, and the patient regresses. If the counter-transference is left completely unaddressed, the therapist may as a consequence of this give up or refrain from writing notes, forget the themes from the previous sessions, refrain from writing to the patient if he fails to show, or simply give up and terminate the treatment.

It is important that the therapist understands how difficult it is for the patient to realise that something is incomprehensible to the therapist. This is deeply traumatizing to the patient. The patient will naturally try to avoid what is painful and so get away from the accompanying affects of emptiness, depression and grief. The feeling of emptiness will often be a defence against depression.

The therapist must balance between on the one hand delving into the barely accessible emotional material and on the other hand convey that he does not want to tear the patient out of a state of seeming security. You have to work towards allowing for another form of security for the patient apart from unconsciously clinging to certain routines, habits, thoughts patterns – all being something often marked by psychotic symptomatology – although the routines are necessary for the patient during extensive periods of time.

A more directive or suggestive technique may involve the therapist in trying to convince the patient that it may be possible to alleviate the intrusiveness of his symptoms (and thereby the blockage in therapy) if he can put his mind to other topics of interest or concern. This technique will by some be applied a lot during the middle phase to lead the patient’s thoughts onto other courses than those that are repeated. Recounting earlier and especially recent experiences may imply a worsening of symptoms by way of for instance hallucinations or delusions. Making connections between worsening symptoms and the potential blockage in therapy needs to be elucidated and explained.

Silvano Arieti (1974) has given guidelines for a strategy: If the patient for instance hears voices, the therapist will make the patient aware of the listening attitude the patient had just before the voices occurred – that the patient, in other words, expected to hear something. This expectation can then be discussed in therapy, and the projective defence addressed, and what is difficult from within the patient’s internal perspective may be contained, addressed, and possibly made understandable for both therapist and patient. Arieti points out that then you have possibilities for localising and treating these mental states – often depression, grief and feelings of inferiority and inadequacy - which the delusion or hallucination carries within itself.
As a consequence of counter-transference or in an attempt to move the therapy on, the therapist may unconsciously try to ‘bribe’ the patient by being nice, unrealistically accommodating, or loveable with the expectation that the patient will then in return and listen to everything he has to say about life, the therapy, and the patient (counter-reaction, contra-phobic reaction). The therapist may unconsciously find that he has earned the right to demand something from the patient. When the patient then does not respond as was expected, futile arguments may easily arise with aggressive undertones. Therapists may also react to the patient’s lack of progress with a kind of passivity. They do not really get involved in what the patient says, or they leave the work to the patient himself – a kind of ‘it’s-up-to-yourself’ attitude.

It is during the middle phase that certain theoretical concepts assume particular significance. Regardless of what the patient is talking about, the reported material is being listened to with a ‘common sense’-ear — which, by the way, is frequently and strangely often absent from therapeutic listening — and what is said is understood from the viewpoint of a theoretical frame of reference. Theory becomes an overall way of understanding everything that takes place during the therapy, regardless of what is being said. The topics of the session will typically be about: the patient’s (life) projects, personality traits, conscious conflicts in relationships, managing everyday tasks, views on the patient’s illness and its treatment, stressing and vulnerable situations in everyday living.

In the course of speaking about these subjects, the patient will present opinions that cannot immediately be classified as abnormal. The plans may however have an unrealistic tinge to them and stand in contrast to the patient’s immediate capacity for acting and ability to plan ahead. The patient’s ability to symbolise is very uneven. Statements that are neutral and meaningful may rather easily change into statements with a fixed meaning. One day the patient is well capable of appreciating that it is realistic to take things step by step, but the next day the patient find that all obstacles may be overcome as easy as anything. One day the patient can appreciate that it is reasonable for the therapist to make demands on the patient during therapy, and the next day the patient thinks that the threats from reality with its many demands can be kept at bay if only the therapist ceases making demands on the patient. If the patient experiences that the therapist at those moments does not live up to the patient’s view of things (and if this happens again and again), it may well be the case that the patient rejects the therapist and distrusts his good intentions. Here it is important that the therapist is containing, resilient and preserves an optimism regarding the prospect of bridging such ‘gaps’.

All psychosis therapy contains supportive elements. Through the supportive technique, some therapists will primarily aim towards:

- Relieving the patient of the experience of imminent crisis by advising and guiding the patient in a concrete way as to how he should tackle, and not allow himself to be governed by, his symptoms: anxiety, phobia, obsessive and depressive thoughts.
- Re-establishing an equilibrium by explaining to the patient the positive and negative aspects of his defence mechanisms.
• Making the therapist a bridge to reality (re-socialisation) even though that sometimes implies setting aside the psychotic experiences and toning down the significance of conflicts.

• Mobilising the healthy sides of the patient’s personality which includes: helping the patient define his reality, giving good advice and guidelines as well as generally maintaining useful defence mechanisms.

The advantage of the supportive technique is that the therapist avoids the patient regressing uncontrollably and excessively in the session and outside it. The disadvantage of the technique is that the transference situations where the patient would have had the opportunity emotionally to sense another human being’s ‘approach’ to his inner universe are easily passed over. With the supportive technique, there is a risk that the psychotic universe and psychotic part of the personality is not addressed and that the patient feels that it is not possible to talk about it. This is an unhelpful side-effect of the supportive technique with its emphasis of advice, counselling and education.

The therapist should learn that regression in itself neither needs to be dangerous nor uninteresting, but that malign regression should be avoided and counter-acted. The latter will induce the therapist to find new ways at moments of regression.

The therapist must understand that the hallucination or the delusion so to speak protects the patient against contact with the concurrent feeling of depression, grief, or inadequacy connected to guilt and shame. On the one hand this defence must be countered, and at the same time the hallucination should be treated as a (from the patient’s perspective) potentially understandable ‘way of thinking’. In a corresponding way the therapist may view the hallucination as a waking dream, day-dream, or as elements better to understand the therapist-patient relation or the patient’s family relations.

In our experience, the patient will often of his own accord try to make sense of the symptoms, and as a therapist you may do well clarifying the meaning of that which may be worked on at the present moment. In that way the therapist may best avoid ‘bad-object’ experiences for the patient, that is, the repetition of experiences which mimic or are similar to what the patient finds hardest. The difficulty for the patient in being able to deal with grief and loss must be accessible to the therapist. The therapist expresses his understanding of this condition, and that it has been difficult for a long time and will continue to be so for some time. The grief and sense of loss will have to change, but that this is a slow process that cannot be resolved immediately. Changes take time, and it is worthwhile to keep trying.

During the middle phase, the patient and therapist will encounter a number of the following problematic situations:

- The patient finds that there is not sufficient progress or any progress at all.
- The patient is about to give up.
- The patient encounters suicidal thoughts or fantasies and perhaps even attempts suicide, because death is much easier to handle than reality.
• Addiction is started or resumed, and patients (deliberately) bring on psychosis.
• The necessity of medication is placed in doubt – often psychosis is preferable to what is experienced as a more withdrawn state of mind.
• Psychotic transference develops.
• Relations to family and friends deteriorate.
• The patient relapses, the condition deteriorates.
• The depression becomes too unbearable.

But in most cases, in spite of some difficulties, the patient and therapist will experience progress, acquisitions of skills and a growing self-esteem, and a more secure adaptation to the daily events of communication, creation of meaning and perspectives for one’s life.

SUPERVISION DURING THE MIDDLE PHASE

The patient will defend himself against the unbearable aspects of his experiences and will at times react negatively against either reality itself or at other times against the therapist and persons that are closest to the patient. But also the therapist will react defensively against what is happening in the interaction.

Therapists with too much zeal and unrealistic idealism will easily come to feel wounded and, contrary to their basic intentions, they may come to react with a latent aggression and therefore counter-therapeutically.

Therapists that have a better hold on their aggressive potentials will not so easily be unhinged and diverted from a containing therapeutic position. But even this neutrality is liable to be put to the test.

Mechanisms of projective identification that prompt fatigue, emptiness, poverty of thought, intransigence, etc., are difficult mechanisms to handle. They subtly penetrate into the therapeutic exchange and incur a sense of guilt.

In the middle phase there are many pitfalls. Ideally, supervision should prevent the counter-transferences of the therapist leading to: power struggle, rejection, prolonged emptiness, lack of reactions to the patient failing to show, premature (desperate, sadistic) termination.

As a therapist you should aim for that openness in supervision which may address any pitfalls once they have occurred. You have to work against your own narcissistic vulnerability. Supervision is supposed to help you gain a sense of conviction that you are good enough at doing the work so that criticism from a more experienced therapist is just a further contribution to a good piece of work.

In the supervision, the following pitfalls may be addressed:

• Being ignorant about your own feelings towards the patient (projective identification, counter-transference, e.g. feelings of guilt and shame, aggressive devaluation)
• Not being able to sense the transference when it is there (counter-transference)
• Responding to transference as if it were a social reality (projective identification)
• Underestimating the significance of the therapist to the patient (feelings of guilt and shame)
• Exaggerating the significance of the therapist to the patient (narcissism and feelings of omnipotence)
• Getting caught up in the negative states of the patient (projective identification and aggression)
• Focusing exclusively on the patient’s pathology (psychotic personality structure) at the expense of life-affirming abilities (the non-psychotic personality structure)
• Letting the patient do all of the work or trying to do it all yourself (aggressive devaluation)
• Acting with silence and the technical style of an unavailable or unresponsive therapist.

THE TERMINATION PHASE

It is difficult to say when the middle phase becomes the termination phase, but it is always a question of a gradual transition. Certain themes – previous self-destructive reaction patterns, ways of thinking and relating – are no longer repeated, disappear from the repertoire, and so the termination phase always becomes a potential new beginning.

Termination of psychotherapy with the patient in the project should not be too short. 3-6 months prior to ending, the therapist summarises what has been worked with in the period thus far and what the therapist thinks likely that the patient will still have to deal with, think about, encounter, etc. In this process, it is important that the images, allegories and metaphors that have been active during the initial and middle phases are reconsidered and are used as possible models for understanding. Therapist and patient must allow for time to talk about how the patient might be able to handle the termination of therapy. What thoughts does the ending provoke? Which strategies may be used to help with the ending? What precautions might need to be taken, and which ones may be discharged?

1-3 months before the end a further summary is prepared on what has been accomplished and what still remains – either to be worked on by the patient himself or in a possible future therapeutic setting. In the summary, an emphasis can be made of those areas in which the patient has recovered autonomy, where things have succeeded for him.

When an actual improvement is dealt with, the therapist must always explore with the patient whether, or not, this is merely the therapist’s own fantasies at play. You have to proceed carefully, as patients may still fear that if they talk too much about the ‘symptoms’ their unpleasant qualities will return. Yet you always have to explore what the process of therapy has meant to the patient and help provide an opportunity for tying up any loose ends. It is important to create perspectives for the patient such as pointing out in very concrete terms what the territory gained may be used for. New perspectives must always be presented to the patient in such a way that the patient can see ideas as options, not as the only possibility.

During the entire termination phase, you also should give the patient the possibility of giving feedback about the therapist’s way of being, helpfulness, presence or absence, ability to listen, etc. The patient who has stayed in therapy will obviously be hesitant about criticising the therapist. With a sense of humour, you may highlight some ‘blunders’ that may have affected the patient, and from which you have learned something, and then tried to modify in your approach to the patient with some success.

During the entire termination phase it is important to keep your empathy with the patient’s experience of shortcomings and lack of progress. This is felt in the
counter-transference of the termination phase. The therapist finds it unbearable to terminate the therapy. There is so much that has not been accomplished. Leaving seems unbearable, or just difficult. Possibly it is the therapist who predominantly harbours these thoughts in relation to the patient, but it is also certain that the patient is to some degree in touch with these feelings too. If they are not addressed during therapy, there is a risk that the patient will be overwhelmed by feelings of ‘lack’ following termination and so risk losing the new ground which has after all been gained.

“Obviously, you are impatient regarding more/further progress. But impatience may be a risk, too. Sometimes one can act really crazy and throw out everything one has gained, just because all the wishes one had in life didn’t come through. It may cause you to lose some of that which you have gained. You will have to protect yourself against that. (If the patient is on medication, the therapist may add: It is therefore important that you don’t stop taking your medication unless you have talked to someone about it”

And once more: During the termination phase the therapist should mainly comment on the creative and life-affirming aspects of the personality. Admonishments are in themselves useless - unless they are understood as caring encouragement. The termination phase should have the character of a joint project coming to a close, that both parties have learned from, and that the patient is now about to find new ways of taking forward for himself.

ADVICE ON CASE NOTES AND SUPERVISION

Many therapists describe what was said in the session by the patient (rarely what they themselves said). This gives a sense of structure, but does not reflect what moves the therapist to intervene, or particularly the way in which the intervention is made.

A good idea is to note the initial remarks by both patient and therapist. And in the same way note how the end of the session runs (remarks from therapist and patient).

Also, when noting a series of events, write what you as therapist said, or would have liked to say (if you had been sufficiently alert). Possibly also note what you do not understand about the material.

Note the most important themes from the session, and the most important thing you thought you said (1-3 examples of each).

‘Monitor’ your counter-transference feeling and fantasies.

Be aware of the presence or absence of processes of mourning during the session. Be aware of suicide risk – and think aloud about this during supervision.

Describe your working hypothesis and your expectation for the next therapy session.
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