The Effectiveness of Psychodynamic Psychotherapy with Schizophrenic Psychoses: A Modified Systematic Literature Review

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Table of Contents

Table of Contents 2

Attestation of Authorship 3

Acknowledgements 4

Abstract 5

Chapter One: Introduction 6

Chapter Two: History 10

Chapter Three: Methodology 14

Table 1 17

Table 2 18

Chapter Four: Biological and psychosocial treatments of schizophrenia and psychoses-historical and recent 20

Chapter Five: Drug treatment of psychosis and schizophrenia 26

Chapter Six: Could childhood abuse and trauma be factors in the causation of 'schizophrenia'? 30

Chapter Seven: How effective is psychotherapy with schizophrenic psychoses 38

Chapter Eight: Conclusion 52

References 54

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgments.

Signed:_____Date: _____

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Abstract

This dissertation seeks to determine whether psychodynamic psychotherapy is an effective treatment for schizophrenic psychoses. This study begins by exploring the historical construction of the term 'schizophrenia' and historical treatment approaches to schizophrenic psychoses. The research uses a modified literature review and although it does not contain case material, it does at times refer to the author's general experience within the area of mental health. The advantages and disadvantages of biological and psychosocial treatments both past and present, for schizophrenic psychoses are discussed. The possible causation of schizophrenia is also investigated and recent research regarding this considered. Little research has been done in the areas of the effectiveness of psychodynamic psychotherapy with schizophrenia and psychosis, and all studies concerning this are controversial. However, a significant body of clinical literature has accrued from psychotherapists who have achieved success in working with clients diagnosed with schizophrenia/psychosis. Although the results and findings regarding the effectiveness of psychodynamic psychotherapy have often been inconsistent and inconclusive, some recent literature, anecdotal reports from psychotherapists and my own personal experience as a therapist all suggest that psychodynamic psychotherapy can play an effective part in working with psychosis, as a component of treatment with additional psychosocial and biological interventions, or as the sole mode of treatment, or as an adjunct to treatment with medication. In researching this dissertation topic, a key theme that emerged is the importance of multiple disciplines working together for the good of the client rather than believing there is only one way of treating this particular client group.

Chapter One: Introduction

"Schizophrenia cannot be understood without understanding despair."

(Laing, 1960, p. 15-16)

My passion for working with predominantly psychotic-level clients[1] developed in the late 1990's. At that time I was a support worker, working in community mental health at a residential facility which provided 24/7 support. Client work was mainly focused on support rather than recovery, and stabilisation or maintaining a client's wellness was considered the ideal outcome. This was largely managed by way of medication and social support. In more recent years, the mental health sector has begun to consider recovery, living well in the presence or absence of one's symptoms, rather than stabilization as the optimum outcome for people. Increasingly, mental health professionals have become aware that psychosocial interventions such as talking and listening are important components in working with the seriously mentally ill. Despite this shift, clinical interventions involving the administration of antipsychotic medication still dominate the treatment of mental illness and I became curious as to how little treatment was provided in the way of psychotherapeutic interventions. Given that my training and experience as a psychotherapist had likely given me a biased view of the subject, I was interested as to what research had been done to ascertain whether psychodynamic psychotherapy was effective in working with clients diagnosed with schizophrenic psychoses.

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[1] The word "patient" and "client" will be used interchangeably in this literature review with respect to authors' use of the two terms

In the course of my research, I soon discovered the controversy around the effectiveness of individual psychotherapy in working with people diagnosed with psychotic disorders. In a study conducted by May (1968), individual psychotherapy was deemed to be not as effective as antipsychotic medication, or even seen as superfluous because it appeared to provide no advantage to clients treated with both.

In contrast, the opposite conclusion was reached by Karon and Vandebos (1981), whose study found individual explorative psychotherapy significantly effective and described psychotherapy as the ideal treatment of choice. The diametrically opposing results of these two particular studies illustrate the divergence of opinion regarding the effectiveness of individual psychotherapy for schizophrenia. This intriguing contrast provided me with the incentive to further explore the research conducted in this area.

Both my own experience working in the New Zealand mental health system and personal accounts from family members of people suffering from psychotic disorders have influenced my bias towards psychotherapeutic treatments with clients experiencing severe mental illness, such as psychosis and/or schizophrenia. Reading Pete Earley's *"Crazy: A father's search through America's mental health madness,"* (2006), I was appalled by the picture of the American mental health system – in particular, how America 'manages' severe mental illness. In Earley's book, American psychiatrist Dr. Torrey states that between twenty five percent and forty five percent of homeless individuals have severe psychiatric disorders. Moreover, Dr. Torrey accuses the American government of spending too much money on what he calls "the worried well – patients divorced by their third husband or fourth wife who were simply unhappy" (p. 222). Torrey argued that tax dollars were better spent investigating schizophrenia.

In his account, Earley, who has a son with a severe mental illness, discusses the importance of individualized care and how it made a difference to his son's recovery. He also gives an in-depth account of his experience of the US mental health system. His behind-the-scenes experience moved and inspired me to take a look at our own far-from-perfect mental health system, and had me feeling grateful that we appear to have moved from treating traumatised human beings as animals and shifting them from jail to jail, naked and suffering, toward an increasingly humane approach. As a beginning psychotherapist working in the mental health system, my experience has been that, at this stage, the majority of my clients have been diagnosed as either psychotic or schizophrenic and have had immensely traumatic childhoods. I believe this is a significant indicator of psychosis and/or schizophrenia, and this view seems to have gained increasing support in recent years.

In a personal communication (January 7, 2009) Earley mentioned that it was not the first time he had received correspondence from someone in New Zealand. Someone with severe mental illness emailed him and said that compared to the American mental health system, New Zealand's was much more highly developed. Consequently Earley had taken some time searching the net and had found New Zealand's interventions far more advanced than those employed in the US. I asked Earley about his beliefs regarding a biological basis for mental illness. I wondered about the pharmaceutical companies. Did he believe that they promote their pills and influence psychiatrists to use these? Had he considered the psychosocial aspect? Earley answered that:

> In my speeches, I talk about how many psychiatrists have been changed into pill pushers in the U.S. This is because they have been taught that mental illnesses are chemical imbalances so all that one has to do is find the right chemical to balance. But I argue that mental illnesses require treating the entire person – including the heart – and not just the brain by shoving a pill down someone's throat. I think we are on the same page. (personal communication, January 7, 2009)

Earley's comment about treating the whole person including the heart left me wondering how we can do this. Stigmatization contributes to a person diagnosed with schizophrenia feeling 'diminished'. My clients say they feel powerless after being diagnosed as 'schizophrenic' or psychotic, and feel they have little or no power or input with regard to their medication. Victimization and powerlessness has been a predominant feature historically for many people diagnosed with schizophrenia, and this appears to continue in the mental health system today. I wonder whether psychotherapy could prove in some way effective in helping to heal the heart and to address this sense of powerlessness.

This dissertation offers a review of the literature addressing the question: How effective is psychodynamic psychotherapy with schizophrenic psychoses? In considering the literature on this topic, and in order to understand the radically divergent views on treatment, it is vital to look briefly at the history of the diagnosis of schizophrenia and psychosis, including some of the cultural and sociological concepts underpinning early conceptions of these illnesses. Next, some possible psychosocial and biological factors that may trigger psychoses will be discussed in terms of the development of theories about causation of schizophrenia, and the corresponding evolution of the treatment of schizophrenia and psychoses will be explored. In summary, the efficacy of psychodynamic psychotherapy as a treatment for psychosis will be considered, and conclusions drawn as to the most appropriate approach within the psychodynamic model.

Chapter Two: History

"There is no such "condition" as "schizophrenia," but the label is a social fact and the social fact a political event".

(Laing, 1967, p. 83)

In considering the historical and cultural constructions of psychosis, John Read (2004b) explains that, four thousand years ago, 'madness' was understood as the result of some evil influence either real or imaginary. The world view in Mesopotamia and Babylon around 2000 B.C. was that evil demons, sorcery or the breaking of taboos were responsible for 'madness', and the treatment of choice was prayer to these demons' adversaries (Porter, 2002; Read, 2004b).

The approach of the ancient Hebrews in the Old Testament was to eliminate the person rather than the behaviour: men and women deemed 'mad' were stoned to death. Read (2004b) comments that, in this culture, madness was considered a result of sinning. It was not until around 400 B.C. that the most significant change in world view came about. Supernatural and moral explanations of madness were replaced with ones based on observation and reason. Priests began to be replaced by physicians as experts on sickness and wellbeing. Hippocrates, a famous physician of that period, was convinced that madness was the result of biological factors and was one of the first to propose the 'medical model' of madness (Read, 2004b).

Read (2004b) states that: "By the fourth century A.D. Constantine had made Christianity the official religion, the Church and State having become an inseparable and immense power" (p. 13). Christ had been seen as a healer of the sick and a caster-out of demons in the New Testament, and thus the Church became the protector of the insane. It

was in this time that ‘mad’ people started being called ‘lunatics.’ In the search for external reasons for insanity, the moon was at one time considered responsible, as the behaviour of the insane was felt to be worse when they were alone at night.

Read (2004b) describes the return to observation and reason in the Renaissance (1500 – 1600) when there was more emphasis on psychosocial origins of ‘madness’. However, the world view was to change again in the latter part of the seventeenth century to the ‘scientific approach’. Read (2004b) states that “psychological and social factors were buried under the relentless drive to discover illnesses that would eventually lead to the invention of schizophrenia” (pp. 15-16).

According to Read (2004c) and Wing (1999), Emil Kraepelin and Eugen Bleuler were the two grandfathers of modern psychiatry. These two men would become jointly responsible for the invention of the term ‘schizophrenia’. In late nineteenth-century Germany, Kraepelin claimed that he had discovered an incurable, degenerative illness in a group of people for whom deterioration began in adolescence and continued, inevitably, into a permanent state of psychological weakness. However, Read (2004c) states:

> Kraepelin repeatedly changed the rules for who has schizophrenia. Whenever he did so he claimed to have discovered ‘a more natural grouping’ creating the illusion of discovery where there is nothing more than yet another meaningless re-categorization. (p. 23)

Working in Switzerland in 1911, Bleuler would expand Kraepelin’s invention of ‘schizophrenia’. According to Wing (1999), Bleuler felt the primary symptom of schizophrenia was cognitive: “a ‘thought disorder,’ with loosening of the associations” (p. 53), and he regarded other symptoms, such as hallucinations and delusions, as additional psychological processes and not of biological origin.

The writings of Kraepelin and Bleuler, as described by Read (2004c), reflected a society with a terrifying need for conformity. What was left? What was considered healthy? Stringent rules implied that we must be heterosexual, abide by rigid roles for males and females, obey our superiors, want to work, like certain colour combinations, be well-behaved (but, if male, not too well-behaved), and speak in a way that psychiatrists could understand. On the other hand, those same rules implied that we must not feel too much or too little, get interested in new ideas, show too much compassion for other people, write too much poetry, play too much music, or try to change the world. Read, Mosher, and Bentall (2004b) pose the controversial question of whether primarily pharmaceutical treatments of schizophrenia were best understood as attempts to cure an illness, or as attempts to suppress socially unacceptable behaviour.

Kraeplin and Bleuler were also concerned, Read (2004c) explains, with proving that behaviours and symptoms of schizophrenia were genetically inherited. They searched for evidence in families of schizophrenics and widened this research. Bleuler did find evidence of what he called hereditary 'tainting' in 90% of the families concerned, although he also admitted that the same evidence of 'tainting' was found in 65% of people considered mentally healthy.

Despite his research, Kraeplin found it difficult to use the results in developing effective therapeutic tools. Engstrom and Weber (1999) state: "Both his blind faith in the impartiality of scientific observations and his uncritical acceptance of those observations as objective 'facts' revealed the deep-seated positivist convictions guiding his psychiatric research" (p. 52). The modern age had discarded prayer and stoning to death as remedies for

madness, but scientists had yet to find the approach that would come to dominate the treatment of psychotic illness – medication.

Chapter Three: Methodology

In this next section I will discuss the methods used in researching the question: "How effective is psychotherapy with schizophrenic psychoses?"

This dissertation will be undertaken using a modified systematic literature review. Aveyard (2007) describes a systematic literature review as a research methodology in its own right. It is a vital tool that provides a synthesis of research and information on a particular subject.

I will endeavour to systematically identify and collect relevant information pertaining to this topic in order to incorporate this into the review. Because I will not use clinical material, the modified systematic literature review does not require formal approval by a research ethics committee. Personal work with clients will only be referred to in a generalized form.

Historically, according to Lebow (2006) there has been significant controversy regarding empirically supported treatments. This issue divided the views of science and practice and still exists today. Clinical research is governed by the positivist paradigm: defined by rigorous evidence-based, quantitative research procedures. Quantitative research will be incorporated at relevant points in this dissertation where the collection of data has been used to measure outcomes.

Most literature regarding research of the effectiveness of psychotherapy is primarily of a qualitative nature. Consequently, it will be necessary to incorporate this approach into my dissertation. Qualitative research, as explained by Averyard (2007) differs from quantitative in that results are descriptive and interpretative.

Silverman (1993) states that, traditionally, qualitative research has been treated as relatively minor methodology. The critique of qualitative research stems back to the 1950's. By the 1970's, the criticism of the earlier positivist approach focused on its possible neglect of social and cultural variables. Silverman (1993) explains that while quantitative research centres on defining, counting and analysing variables, qualitative research prefers to describe and illuminate the meaningful social world as prescribed by the interpretive paradigm.

My search of the literature was conducted primarily in one specialised health computer database, PsycINFO. Two other principal databases PEP and PsycARTICLES, are automatically searched within PsychINFO. This database provided citations and abstracts which I used to further ascertain the relevance of articles to my dissertation topic. Relevant searches allowed either the ability to download the full text or to request the desired publication from inter-loan library services.

My additional research included books accessed through the catalogue section of the AUT library and recommendations from outside resources related to the dissertation subject: in particular those books and journals that have been recommended by the International Society for the Psychological Treatments of the Schizophrenias and other Psychoses (ISPS).

Additional resources included my supervisor's personal recommendations and those of my colleagues who work in the field of severe mental illness. Other resource avenues included articles considered relevant by external supervisors, staff at AUT and lecturers that have had experience in psychosocial interventions and treatments of schizophrenia and psychoses.

Other important resources that I have accessed included seminars I have attended regarding the importance of psychosocial interventions germane to working with this particular client group. These seminars have influenced my work so far and are consistent with my own personal experiences with clients. Of particular use was a seminar conducted by Richard Bentall, who has a great deal of expertise regarding working with psychoses and is the author of "Madness Explained: Psychosis and Human Nature" (Bentall, 2003).

As part of the initial literature search, selection criteria were used to exclude articles not directly related to psychosis or schizophrenia, duplications of the same material and those that were not written in English.

Relevant research will be analysed, considered and critiqued in order to provide an in-depth understanding as to whether psychodynamic psychotherapy is effective as a treatment for working with schizophrenic psychoses. If so, at what level should psychotherapy be carried out; interpretative, expressive or supportive? The history of treatments of psychosis and schizophrenia will also be discussed. In particular, the different viewpoints regarding biological and psychosocial (nature versus nurture) and the different ways of determining the causes of these disorders will be considered. Pertinent research will be studied and critiqued regarding these contradictory view points.

I will also examine research regarding the possible significance of childhood trauma and abuse, particularly childhood sexual abuse, which may prove to be an important causal factor in the development of schizophrenic psychoses. Other reasons concerning possible psychosocial factors will also be touched on if deemed significant in the course of the research. I will not include specific information about any of my clients, but instead will draw on my general experience in describing possible clinical scenarios.

As shown in Table 1, key word search results from the database PsycINFO:

Table 1

	Searches	**Search Type**	**Results**
1	psychosis/or acute psychosis/or chronic psychosis or schizophrenia/	Advanced	66714
2	psychotherap$.mp.[mp=title, abstract, heading word, table of contents, key concepts]	Advanced	125766
3	psychosis.sh.	Advanced	14184
4	acute Psychosis.sh.	Advanced	734
5	chronic Psychosis.sh.	Advanced	195
6	psychotherapy/or psychoanalysis/or psychodynamic psychotherapy/or supportive psychotherapy	Advanced	66447
7	2 or 6	Advanced	143502
8	7 and 4	Advanced	48
9	7 and 5	Advanced	14
10	7 and 3	Advanced	1647
11	Schizophrenia/or acute schizophrenia/or paranoid schizophrenia/or undifferentiated schizophrenia/	Advanced	56591
12	6 and 11	Advanced	1146

13	6 and 11 and 3	Advanced	86
14	limit 13 to English language	Advanced	63

All texts not in English were excluded. Texts that had no relevance to this dissertation topic were also excluded. This included therapies other than psychodynamic psychotherapy.

As shown in Table 2, key word search results from AUT library catalogue:

Table 2

Searches	**Results**
psychosis and psychotherapy	16
schizophrenia and psychotherapy	41

The database and library catalogue referred to previously, after applying the inclusion/exclusion criteria, relevant texts or books were downloaded, filed to be read or accessed from the AUT library ready to be applied to this dissertation.

ISPS articles and books were accessed also within the AUT database and also within the library. ISPS articles were found mostly within the PEP Web database or requested by using inter-loan library services available only to staff or post-graduate students. This book series was easily accessible using the catalogue section although some books were not accessible at the AUT library.

Using all these above resources, I have managed to glean a significant body of literature regarding all aspects of my dissertation without ruling out literature that may prove relevant from outside sources.

Relevant outside resources emerged later after beginning to read the articles I had already collected. Those articles that were particularly relevant to my research contained references that also pertained to my dissertation topic. A number of these additional references were also used as part of my research and consequently my methodology.

Chapter Four: Biological and psychosocial treatments of schizophrenia and psychoses-historical and recent

"Insanity – a perfectly rational adjustment to an insane world".

(Laing, 2009)

This chapter will explore research into both biological and psychosocial explanations for the etiology of 'schizophrenia', and consider how these have impacted on the development of treatments. Both research into, and treatments of schizophrenia have been controversial over the years. As described in the historical section of this dissertation, biological and psychosocial theories have battled for dominance in the treatment of mental illness. Since early in the 20th century the biological paradigm has dictated treatment for schizophrenia, sometimes with shocking results.

According to Read and Masson (2004), treatment of schizophrenia has been led by the 'medical model' since the early 1900's. Drug companies have traditionally supported this stance – and have made significant financial gains as a result. Psychiatry, supported by sponsorship from the pharmaceutical industry, has largely ignored the importance of environmental experiences in psychosis, thereby creating a diagnosis – schizophrenia – that is at best reductionist and at worst, stigmatizing and severely limiting. The result has been that recovery from schizophrenia has effectively been regarded as impossible without medication. Historical biological attempts to 'manage' people diagnosed with schizophrenia as described by Read and Masson (2004) have included the lobotomizing, electro-shocking or drugging of millions of people. Efforts to assist or to understand the distressing and confusing symptoms of schizophrenia have largely been ignored by the medical model (Read et al., 2004b). Even in comparatively recent times, psychosocial factors were often not considered to be

contributing factors in the causation of schizophrenia. In 2003, the US National Institute of Mental Health in the United States, described schizophrenia as "a chronic, severe, and disabling brain disease" (Health, 2009; cited in Read et al., 2004b, p. 3).

In spite of the dominance of the medical model, psychotherapeutic approaches to schizophrenia were being used even as early as the beginning of the 20th century. Eugen Bleuler, a pioneer within the field of psychotherapy, initially named schizophrenia, 'Dementia Praecox'. 'Dementia' referred to the progressive deteriorating course of both emotional and cognitive processes while 'praecox' indicated the early age of onset in previously healthy individuals. Although at this stage, little was known about the treatment of 'dementia praecox', followers of Freud (a disciple of Bleuler) began treating schizophrenia with more active psychotherapy. It was believed at this time that patients could recover and function outside of institutions. Unfortunately, according to Rosberg (2000), a split quickly emerged between the biological and psychological viewpoints. The development of pharmaceutical treatments had the effect of turning many practitioners away from furthering their understanding of how relationships between therapists and patients made the difference in the outcome of treatment, while pharmaceutical companies gained enormous revenue from marketing their medications as the best treatment available. This had the effect of marginalising psychotherapy as a treatment for schizophrenia.

Historically, bio-genetic theories of madness have dominated the 'treatment' of mental illness. As explained above, procedures such as electroshock, lobotomy and sterilization have been routinely used by psychiatry in the past and have actually been used in the past ten years (Read & Masson, 2004).

A sinister outcome of the changing views of schizophrenia was that, in 1924, Bleuler campaigned for compulsory sterilization of mental patients. "The eugenics movement, which aimed at improving 'race hygiene' by eliminating tainted genes shared Bleuler's commitment" (Read & Masson, 2004, pp. 35-36). Disturbingly, a number of nations would use psychiatry's bio-genetic theories to justify moves to eliminate the so called 'tainted genes' of mental illness. Sterilization began in Germany in 1933 and approximately 350,000 patients had been sterilised by 1939. In the 1930's, in Germany, Kallman (1955), argued that any relatives of patients that were diagnosed with schizophrenia should also be sterilized.

In 1941 the Hadamer Psychiatic Institute in Nazi Germany celebrated the murder of their 10,000th mental health patient. Koupernick (2001; cited in Read & Masson, 2004) stated that in 1939, plans to murder all mental patients were actioned by German psychiatric institutions. Murders were called 'euthanasia', as these measures were considered mercy killings, or help for those that psychiatrists felt had no cause to live. Figures for 'euthanasia' in Germany alone totaled over one quarter of a million.

The extent of the killing of mental patients elsewhere is generally unknown. However, in 1940, 40,000 patients in France alone were intentionally starved to death. Wertham (1966; cited in Read & Masson, 2004) stated that Jewish mental patients were excluded during this period as they were not considered deserving of psychiatric 'euthanasia'. As Read and Masson (2004) speculate "perhaps it had been decided that the Jewish race should be left to genetically degenerate while the Aryan race was cleansed of schizophrenia and other undesirable genetic material" (p. 37). Almost all psychiatrists involved in these killings managed to escape censor.

Historical events in the treatment and diagnosis of schizophrenia and other 'undesirable illnesses' appeared to highlight the power of psychiatry. Psychosocial implications were rarely considered; recent research in this area however, is proving informative. Patients' family history has proved enlightening. For example, Bentall (2003) explains that our brains are affected by our experiences. Traumatic experiences in childhood can produce enduring changes and can impair the functioning of the human brain. Evidence at this stage indicates that there is little support for 'genetic tainting'.

Read and Hammersley (2006) argue that relentless pursuits of biological explanations for schizophrenia have allowed us to not have to spend money on, and to avoid facing human distress. Again, the pharmaceutical companies have had a major role to play in this area with aggressive sales campaigns.

As Read and Hammersley (2006) state:

> One of the first research papers emanating from the World Psychiatric Association's campaign to improve attitudes about schizophrenia portrays as 'sophisticated' and 'knowledgeable' the belief that schizophrenia is a 'debilitating disease' caused by a biochemical imbalance. The study was funded by drug company Eli Lilly. (p. 274)

The adherents of the biological paradigm have been intent on discovering a scientific reason for 'schizophrenia'. Various hypotheses as to the etiology of schizophrenia have dominated different eras in history, but as yet evidence has been inconclusive (Read, 2004a). The most logical way to prove that 'schizophrenia' is a medical illness has been to try and find evidence that 'schizophrenia brains' are different from 'normal brains'. However, Bentall (2003) states that:

> Because our brains are affected by our experiences, peculiarities in the size of its anatomical components, in neuroactivations when we perform particular tasks, or in the biochemical transactions between neurones, can often be just as readily attributed

> to the impact of the environment as to causative biological factors such as early brain damage, viruses or endogenous neurotoxins. (p. 174)

Antipsychotic medication, the main treatment of schizophrenia by clinical psychiatry can effect a reduction in symptoms and has proven to work with some clients. However, Steinman (2009) argues that: "antipsychotic medication merely covers over the disturbed and confused thinking that underlies such severe conditions. The best that is hoped for is an adjustment to reality, not a working through of underlying psychological issues and emotions which have been warded off" (p. xiv).

Taking another angle, Snyder (1974) addresses a comparatively recent development one favoured by more positivist scientific professions such as psychologists and psychiatrists. This is the theory that over-activity of dopamine, a neurotransmitter, might be seen as the cause of schizophrenia. This theory has subsequently been explored and challenged. Snyder (1974) stated that administration of anti-psychotic medication caused a blockage of the dopamine system. The neurons recognise the sudden absence of neurotransmitter molecules at the appropriate receptor site and transmit a message back to the dopamine neurons saying something like, "we don't have enough dopamine. Please send us some more! Where upon the dopamine neuron in question proceeds to fire at a more rapid rate" (Snyder, 1974, p. 241).

The term 'treatment' implies action in helping clients to relieve themselves of symptoms, even to cure them. It could be argued that the medical model appears to only incorporate management of symptoms. Describing another view of treatment, Perry (2006) explains that "the alternative paradigm is based on the concept of a 'therapy' that gives respectful heed to the psychic process underlying the symptoms" (p. 1).

In the same vein, Karon (2007) expressed his views in a radio broadcast regarding case studies and research concerning clients diagnosed with 'schizophrenia'. Karon (2007), who is a Professor of Clinical Psychology, felt that schizophrenia was better understood as a "chronic terror syndrome" (p. 1). Clients that became catatonic demonstrated the same rigidity observed in both animals and humans when they felt they were on the verge of dying. For these patients, the 'fight or flight' syndrome was replaced by a terror so profound that it causes paralysis. Given this, Karon suggests, a therapeutic approach that worked to reduce fear, and to increase a sense of safety and trust might be appropriate.

Joseph (2004) writes about the common assumption that schizophrenia is predominantly bio-genetically based. This has effectively resulted in research being biased against considering psychosocial factors such as childhood abuse as being possible determinants for schizophrenia and psychoses. This has also contributed to psychosocial interventions being deemed less important than medication.

In conclusion, biological treatment of schizophrenia has been, and is the foremost intervention for this client group since the early 20th century. This has largely rested on the assumption that schizophrenia is bio-genetically based. Tragically, this has led to the use of some inhumane methods of 'managing' schizophrenia. Little attempt appeared to be made then to consider environmental factors as contributing to severe mental illness, and this attitude has persisted even as more humane treatments have been developed. As noted above, more recent research is suggesting that psychosocial factors may play a large part in the causation of this illness, opening up the possibility that psychosocial interventions such as psychodynamic psychotherapy may prove effective in helping at least some of this client group.

Chapter Five: Drug treatment of psychosis and schizophrenia

"There is a great deal of pain in life and perhaps the only pain that can be avoided is the pain that comes from trying to avoid pain".

(Laing, 2009)

In this chapter I will briefly address the issue of pharmacological treatments of schizophrenic psychoses; some of the beneficial and detrimental effects of these; and the possibility of medication enhancing or decreasing the effectiveness of psychotherapy with this client group.

Mosher, Gosden, and Beder (2004) note that chlorpromazine (Thorazine) was the first anti-psychotic drug marketed in the early 1950's. The Food and Drug Administration approved the use of Thorazine in 1955, and by the late 1950's it was the predominant drug used for treatment of schizophrenia and other related illnesses. The marketing of this drug aimed to convince psychiatrists of its efficacy – and the success of this endeavour ensured that the drug companies made millions. In advertising the effectiveness of chlorpromazine drug companies managed to generate "a number of unsupportable beliefs about what these drugs actually did" (Mosher et al., 2004, p. 115). However, a major issue that appeared to be neglected in the advertisements was the often debilitating side effects that were the result of chlorpromazine use. A great many of these side effects occurred after numerous years of drug use, and some proved irreversible.

My own experience as working either as a support worker in mental health or as a psychotherapist has given first-hand experience of the adverse side effects of anti-psychotic medication. Clients I have worked with that have taken anti-psychotic medications have experienced some debilitating side effects, including Parkinsonian-type symptoms, weight

gain and increased salivation. I have seen some clients taken to hospital emergency departments as a result of the harmful effects of anti-psychotic medications. Their prognoses were sometimes deemed serious and life threatening, with instant withdrawal of treatment of a certain drug necessary. Despite drawbacks such as these, the pharmaceutical industry has continued to promote the biological view of schizophrenia and the necessity of pharmacological treatment, while ignoring the need to consider other therapeutic approaches, even though many clients find these useful in coping with emotional distress.

According to Black (2001; cited in Glasser, 2003) psychiatry has an extremely close relationship with the pharmaceutical industry. Psychiatry's journals, conventions, and professional associations are all substantially underwritten by the pharmaceutical industry. Black describes this situation as scandalous, and claims that drug therapies are unsafe. Twenty-five years after the first introduction of anti-psychotic medication in the 1950s, an American Psychiatric Association Task Force confirmed that prior studies concerning anti-psychotic medications were being neglected. Roughly "40% of chronic users of these drugs went on to develop tardive dyskinesia, a Parkinsonian-like movement disorder indicative of permanent brain damage" (Black 2001, cited in Glasser, 2003, p. 205) . Latest evidence as described by Black "supports rates of neuroleptic-induced brain damage exceeding an astounding 5 percent per year of usage" (2001; cited in Glasser, 2003, p. 205). Glasser further notes that Black has done a great amount of research to support these claims.

On the other hand, medication has proved to be an important intervention in helping clients stabilise and control their symptoms. As explained by Vassilev, Groshkova, and Jenkov (2008), this can improve receptivity to psychotherapeutic interventions. Despite its many debilitating side effects, for some clients medication has proven effective in managing

symptoms. The most important role of medication in rehabilitation as reported by Manuu and Soscia (2008) is that of reducing positive psychotic symptoms, which for many clients has made it possible it for psychotherapy to be introduced and has enhanced its effectiveness as a treatment.

For others however, continued use of anti-psychotic medication can impede the effectiveness of psychotherapy. As stated earlier, dehibilitating side effects from anti-psychotic medications may interfere with recovery. Furthermore, Mannu and Soscia (2008) state that these side effects and the worsening of cognitive functions weaken the already vulnerable client, reducing the resources that therapeutic possesses are trying to implement and enhancing the social withdrawal that is seen in schizophrenic disorders.

Mannu and Soscia (2008) discuss the need to refute pharmacotherapy as the only approach to treatment for schizophrenia. They suggest that there needs to be a compromise between the biological and psycho-social paradigms. Both paradigms are considered important tools in the rehabilitation of clients with schizophrenia, and may play vital roles at different stages of the rehabilitation process. Mannu and Soscia go on to describe the context in which medication should be prescribed: "The taking of medication should be viewed in this context; it is only a means to reach an optimal state so that other interventions could work better" (2008, p. 117).

Widening the debate, Mannu and Soscia (2008) ultimately assert the value of all treatment being carried out within a therapeutic community paradigm. In this environment, the emphasis is placed on recovery and the beliefs that clients' lives can improve and they may be able to function in the 'real world'. This approach utilises an interdisciplinary way of working that involves a clinical worker, family, support worker, peer support worker and,

ideally, a therapist. Communication between all stakeholders concerned with the wellbeing of a client is vital for the success of treatment. This approach truly advocates the treatment of the whole person, attending to social and cultural needs as well as physical, emotional and spiritual.

The full history of anti-psychotic medication, including more recent medications, is beyond the scope of this dissertation. I have instead touched briefly on how the dominance of the biological paradigm has influenced the use of psychotherapy as a treatment for schizophrenia and other psychoses, and the possible impact of anti-psychotic medications on the efficacy of psychotherapy.

Chapter Six: Could childhood abuse and trauma be factors in the causation of 'schizophrenia'?

"The experience and behaviour that gets labeled schizophrenic is a special strategy that a person invents in order to live in an unliveable situation".

(Laing, 1967, p. 79)

This chapter will explore the possibility that childhood trauma and abuse are potential factors in the causation of schizophrenic psychoses. Recent research that suggests psychotherapy is an effective tool in the treatment of these disorders will also be discussed.

In contrast to the theoretical split that has existed between opposing camps in the debate over the etiology and treatment of schizophrenia, recent brain research now points a way to an integration of the biological and psychosocial paradigms in understanding the impact of childhood trauma. As explained by Read, Fink, Rudegeair, Felitti, and Whitefield (2008), the Traumagenic Neurodevelopmental model of psychosis was based on research demonstrating biological differences as evidence for schizophrenia being a brain disease. These neurological differences have now also been found to be the same in the brains of abused children (Read et al., 2008). In-depth research into the neurobiological component of psychoses and schizophrenia is unfortunately beyond the scope of this dissertation, but it seems important to note this exciting new development.

The overwhelming majority of relevant studies have shown that childhood abuse and trauma are important contributory factors in severe mental illness: the more severe the abuse, the more significant the psychological problem. Childhood neglect and parental loss have also been central issues in severe mental illness. In 1939, as described by Read, Goodman, Morrison, Ross, and Aderhold (2004a), it was found that thirty eight percent of 'dementia

praecox' (schizophrenic) patients had experienced the loss of a parent during early childhood. Many patients diagnosed with schizophrenia were also found to have suffered either sexual abuse or incest as a child. High numbers of patients admitted to psychiatric hospitals have revealed experiences of both physical and/or sexual abuse. In addition, co-morbid diagnoses or symptoms such as depression, anxiety and substance abuse were also not unusual (Read et al., 2004a).

The conflicting views regarding biological and psychosocial viewpoints can be confusing. A good example of this conflict is provided in a study by Read et al. (2008), which addresses different views regarding vulnerability to stress and the connection to schizophrenia. Heightened vulnerability to stress has been regarded by biological theory enthusiasts as genetically-orientated and as a pre-requisite to psychosis. Offering a contrasting view, Zubin and Spring (1977; cited in Read et al., 2008) published a landmark paper entitled "Vulnerability: A New View of Schizophrenia". Here Zubin and Spring clearly deny the existence of 'acquired vulnerability'. In their view, vulnerability is directly "due to the influence of trauma, specific diseases, perinatal complications, family experiences, adolescent peer interactions, and other life events that either enhanced or inhibited the development of subsequent disorder" (p.109).

The imbalance of views in published research was addressed by Read et al. (2008), who found that biological research outweighed research into social causes by a factor of fifteen to one. Published research regarding this disorder also favoured biological aspects: of 1,284 publications, only thirteen related to child abuse and poverty. In response to these findings, Read et al. questioned why many professionals are seemingly uninterested in the childhoods of clients. Two possible explanations to this may be an aversion on the part of

mental health professionals to hearing awful things that may happen in childhood, and the powerful influence of the pharmaceutical industry in maintaining the focus on biological factors.

Sharfstein (2005), the then president of the American Psychiatric Association, warned against the rigidity of only speaking to the biological component of mental illness:

> If we are seen as mere pill pushers and employees of the pharmaceutical industry, our credibility as a profession is compromised. … As we address these Big Pharma issues, we must examine the fact that as a profession, we have allowed the bio-psycho-social model to become the bio-bio-bio model. (p. 3)

Larken and Read (2008) also note that "contribution of childhood trauma to psychosis has been long overlooked in favour of the dominant bio-genetic paradigm" (p. 2).

My own experience in treating psychotic/schizophrenic diagnosed clients has been that many have experienced traumatic childhoods tormented by neglect and various forms of abuse. In my view, this must have had an enormous impact on clients' lives, and indicates the possibility of these factors having a causal role in psychoses and schizophrenia.

In the same vein, Larkin and Read (2008) state that there is a growing body of research that has examined childhood environmental factors, in particular trauma, and whether it may have bearing on schizophrenia and/or psychoses. There have been numerous studies (e.g., Bebbington et al., 2004; Janssen et al., 2004; Lataster et al., 2006; Read, Van Os, Morrison, & Ross, 2005; Scott, Chant, Andrews, Martin, & McGrath, 2007; Shevlin, Dorahy, & Adamson, 2007; Whitfield, Dube, Felitti, & Anda, 2005) indicating that childhood trauma is prevalent in those clients that have been diagnosed with psychotic illnesses. These results are indicative of a causal relationship. However, while data in the area of childhood trauma has been plentiful, it has been difficult to draw firm conclusions about causation.

Other specific types of trauma may also be contributing factors to reasons for psychosis. As Read et al. (2008) state, psychosocial factors certainly have been causal in most other mental health problems such as PTSD, eating disorders, personality disorders, depression, anxiety disorders and dissociative disorders.

Larken and Read (2008) refer to recent research published from 1997 to 2003, which concludes that childhood trauma is associated with numerous mental disorders such as "eating disorders, substance abuse, phobias, multiple personality disorders, irritable bowel syndrome, rheumatoid arthritis, and autoimmune disorders" (p. 3). Also, those who report childhood sexual abuse are more likely to have experienced adverse childhood experiences (ACE). Relationships between childhood trauma, and negative social exposure have consistently surfaced in research literature, lending support to the hypothesis that abuse is also a causal factor in psychosis.

Despite the insights offered into other conditions by the consideration of psychosocial factors, reviews of the North American psychiatric literature over the last 40 years have largely neglected social causes being possible factors in the causation of schizophrenia and psychosis in favour of biological models. Bentall (2006; cited in Larkin & Read, 2008) challenges these models. He argues that causes of schizophrenia and psychosis "lie on a continuum with 'normal' functioning, and suggest that contemporary conceptualisations of 'schizophrenia', 'bipolar disorder', and associated complaints should take into account the role of adverse environmental factors" (p. 3).

Read et al. (2005) conducted a comprehensive review in 2005 and examined studies of psychiatric patients where at least fifty percent were diagnosed with psychotic conditions. Sixty nine percent of female patients reported childhood sexual abuse (48%), and/or

childhood physical abuse (48%). Male patients reported childhood sexual abuse at (28%) or childhood physical abuse (50%). Read et al. also viewed these rates as an underestimate, given that childhood sexual abuse is under-reported by patients, and by men in particular.

Lending support to the hypothesis that environmental factors contribute to the causation of schizophrenic psychoses is a study conducted by Bebbington et al. (2004), which found that clients that met the criteria for psychosis were 15.5 times more likely to have experienced sexual abuse than those who had not. Another strong theme that emerged with this particular group was experiences of victimisation. The overall conclusion suggested that social factors had an important contribution to play in the diagnosis of psychosis. The same year that Bebbington and colleagues conducted their study, Janssen et al. (2004; cited in Larkin & Read, 2008) researched 4045 adults in the Netherlands. They found that experiences of childhood sexual, physical, emotion abuse and neglect before the age of 16 were predictive of positive psychotic symptoms in adults. Those that "experienced the most severe abuse were 48.4 times more likely to develop 'Pathology level' psychosis than those who had not been abused" (p. 5).

The fourth largest research study was carried out by Whitfield et al. (2005), where 17,337 Californian adults were assessed regarding adverse childhood environmental factors (ACE), and their relevance to the risk of hallucinations. Hallucinations significantly increased when all eight graded ACEs were assessed. These included childhood sexual abuse, childhood physical abuse, and childhood emotional abuse. After controlling for age, gender, education and educational attainment, race and substance use/misuse, those that had experienced seven or more different types of ACEs were found to be 4.7 times more likely to experience hallucinations than those who reported no ACEs.

In a survey conducted by Shevlin et al. (2008), data was used from the National Comorbidity Survey (NCS) and the British Psychiatric Morbidity Survey (BMPS). 14,362 Americans between the ages of 15 and 74 were surveyed to estimate the effect of cumulative traumatic experiences on psychosis. Results from the NCS sample showed sexual molestation, and physical abuse as the most significant factors associated with psychosis while sexual abuse was the strongest factor for psychosis in the BMPS sample. The same group also conducted another survey using the NCS to explore the relationship between hallucinations and childhood trauma. 5877 Americans were surveyed and it was found that childhood rape and molestation before the age of 16 was significantly associated with visual, auditory, and tactile hallucinations. Consistent with the previous research, childhood sexual trauma was significantly associated with auditory hallucinations.

Furthermore, Larkin and Read (2008) state that another survey directed by the Australian National Survey of Mental Health & Wellbeing showed that childhood trauma, particularly rape, is associated with delusions. 10,641 adults were assessed for delusional experiences within the previous 12 months and exposure to traumatic events, in particular PTSD. One weakness to this particular study is that there was no specific time frame for trauma to be identified, so the possibility of establishing whether trauma preceded the development of delusional experiences was not viable.

Studies regarding victimization in childhood have also proved to be indicators in determining psychosis, and schizophrenia. A number of researchers (Read et al., 2008; Spauwen, Krabbendam, Lieb, Wittchen, & Van Os, 2006) reached similar conclusions and suggested that the association between victimisation in childhood and non-clinical psychotic

experiences in early adolescence may indicate a risk of developing psychotic disorders later in life.

In November 2005, Acta Psychiatrica Scandinavica published the first full literature review of more than 40 studies in this area. Hammersley, Read, Woodall, and Dillon (2007) stated that this review highlighted the significant relationship between childhood trauma and psychosis. After reading this review, James (2005), a respected British clinical psychologist and writer, suggested that the psychiatric establishment was about to experience an earthquake that would shake its intellectual foundations.

As this chapter suggests, biological research into the causation of schizophrenia and psychoses has outweighed research into the possibility of environmental reasons contributing to these diagnoses. The research that has been done in the area of psychosocial factors represents a serious challenge to the accepted doctrine that biological factors are the primary cause of severe mental illness, and has enormous implications for treatment.

Silver (2005) discusses the importance of keeping abreast of developments in neuropsychiatry which are including erudite explanations that there is overwhelming evidence "that the physiological changes in the brains of people suffering from psychosis are not inherently different from those seen in any condition of high anxiety. Trauma victims look quite similar in MRIs" (p. 696).

In considering treatment for schizophrenia and psychosis, Steinman (2009) suggests that neurological changes that occur as a result of traumatic events can also be altered again in the course of a healing intensive psychodynamic psychotherapy. Steinman cites research done on the "ameliorative effects of the psychodynamic psychotherapy of schizophrenia on brain chemistry, neuronal pathways and behaviour, with anxiety and the flow of alerting

brain chemicals diminishing as helpful psychotherapy proceeds" (p.16). This suggests that, when we consider the diagnosis of schizophrenia as being trauma-related, psychotherapy may be seen as an effective intervention.

Chapter Seven: How effective is psychotherapy with schizophrenic psychoses?

"Madness need not be all breakdown. It may also be break-through. It is potential liberation and renewal as well as enslavement and existential death".

(Laing, 1967, p. 93)

The preceding chapters have been relevant in setting the stage to address my dissertation question: How effective is psychotherapy with schizophrenic psychoses? It seems important to understand the role historical constructions of 'schizophrenia' have played in the conflicting views between the biological, and psychosocial standpoints, and the divergent views on treatment.

Essentially biological enthusiasts believe that at the core of psychosis is an underlying vulnerability to stress, while psychosocial enthusiasts favour traumatic or adverse childhood environmental factors as being triggers or exacerbates of psychoses. When I reflect on both these conflicting views, I am reminded of the classic paradox: Which came first, the chicken or the egg? The diagnostic label 'schizophrenia' has so often been applied to those people that have been rendered powerless, who have experienced little or no control over their own future, who may at times have lost all sense of being a real human being. The label refers to an illness, and not to the real person behind that label. I have seen the pain of how demoralizing that label has been, and the need for people to be understood, not judged. In this chapter, I will consider how psychotherapy might play a valuable role in promoting this understanding.

Earley (2006) refers to an article by Garret, the sister of a man diagnosed with schizophrenia, in which she recounts a story that dramatically illustrates the effect of showing the difference between the label, and the person who is suffering from an illness.

Using techniques from psychodrama, actors played the roles of her brother and the illness. Garret describes the 'cognitive thump on the head' she experienced upon watching this drama. She was deeply moved by watching 'the illness' relentlessly reciting its lines, and the patient's unavailing struggles to escape. The illness refused to back off. No amount of yelling or talking made any difference. The illness did not sit quietly, and behave. Garrett saw and felt the disconnection and understood much better that her brother was not his illness. It was not his fault (cited in Earley, 2006, p. 343).

Historically, there has been some reluctance in using dynamic psychotherapy with psychosis, perhaps due to the initially discouraging research. In a study of five treatment methods, May (1968) found that when a combination of drugs and psychotherapy were used it showed no superior results than using drug treatment alone. However, a later study by Grinspoon, Ewalt, and Shader (1972) found that drug treatment plus psychotherapy had a greater effect than psychotherapy alone. Another study contrasting the effects of psychopharmacology and dynamic psychotherapy initially showed drug treatment to be more effective with psychotherapy, but only showing this effect during the initial six to twelve month period of treatment (Hogarty, Goldberg, Schooler, & Ulrich, 1974a, 1974b). I wonder whether this may be due to a therapeutic alliance needing to be formed before any work could be done. It takes some time to form a therapeutic alliance with clients diagnosed with schizophrenia, as one of the most fundamental issues this client group tends to struggle with is trust. As a therapist, it is my experience that it is only when a therapeutic alliance is

formed that issues regarding traumatic histories and abuse are disclosed more fully. My own personal experience is that when I have a formed a therapeutic alliance with my clients, this has formed the main foundation of the therapy.

Another study conducted by Smith, Glass, and Miller (1980) comparing psychotic patients receiving drug treatment to those receiving both antipsychotic medication, and supportive psychotherapy showed significant results. Drug treatment alone had an effect size of 0.44, whereas antipsychotic medication, and psychotherapy combined had an effect size of 0.83. These analyses indicate that psychotherapy of a supportive kind was effective for psychotic-level patients.

In a significant study done by Karon and Vandenbos (1981), impressive results for explorative psychodynamic psychotherapy with clients diagnosed with schizophrenia were reported when delivered by experienced therapists. However, this has not been replicated in other studies.

A research study done by Gunderson, Frank, Katz, Vannicelll, Frosch, and Knapp (1984) indicated that the effectiveness of supportive psychotherapy was comparable with insight oriented psychotherapy. Gunderson et al.'s study did not examine the effectiveness of psychotherapy, but instead compared insight-oriented psychodynamic psychotherapy with supportive psychodynamic psychotherapy. A sample of 95 schizophrenic patients were treated for a minimum of six months by one or other of these two treatments with the results-examined over a 2 year period. Gunderson et al. found that patients treated once a week with supportive psychotherapy did at least as well as patients receiving insight-oriented psychotherapy. Supportive psychotherapy proved better in terms of time in hospital, role

performance and symptomatic and social functioning. Insight-oriented psychotherapy showed greater improvement in the areas of ego functioning and cognition.

Gunderson et al. (1984) also examined the importance the therapeutic alliance had on clinical state. They noted that there was difficulty in maintaining an alliance with patients diagnosed with schizophrenia, and that it was crucial to develop an alliance within six months. A good therapeutic alliance was associated with decreased psychopathology, decreased medication, and increased compliance. It is also interesting to note here, as mentioned earlier, that clients diagnosed with schizophrenia also have significant trust issues, and that this may impact on the length of time it takes to form an alliance.

It is important to note the limitations of the study conducted by Gunderson et al. (1984). This study commenced with a sample size of 95 patients, but by the 12 month follow up the sample size had decreased to 72, and by the 24-month finish, only 47 patients remained, 22 of these receiving insight-oriented psychotherapy and 25 receiving supportive psychotherapy.

In considering the value of psychotherapy for people who experience psychotic illness, a number of writers have made recommendations as to how this treatment can be used to greatest effect. Many, including Gottdierner (2006), and Karon and Vandenbos (1981) reinforce the need for therapists conducting psychotherapy with clients that experience severe mental illness to have sufficient knowledge in this area, and to have a skilful supervisor who has had success in working with this client group.

In working with this client group, most agree that the therapist needs to be aware of the client's potential sensitivity to overstimulation. This again connects with the importance of developing a therapeutic alliance. Drake and Sederer (1986a, 1986b) argue that therapists

must respect the patient's need for distance, and reinforce that the most crucial issue in treatment is the focus on forming a trusting relationship. Other identified factors include: focusing on positive aspects of the patient; enhancing self esteem; avoiding regression; and promoting stability.

In the same vein, Coursey (1989) discusses the role of psychotherapy in the current predominant biological revolution. Again, the main elements Coursey feels are integral to successful therapy are: a complementary role between drug treatment, and psychotherapy; modified interventions when the patient becomes actively psychotic; and the critical task of forming a therapeutic alliance.

Significant advances have been made over the last two decades regarding psychodynamic supportive psychotherapy. A long-term follow up of patients from the Menninger Psychotherapy Research Project by Wallerstein (1986) provided a powerful boost to supportive psychotherapy. According to Wallerstein, there was little difference in outcome between the use of explorative psychodynamic psychotherapy and supportive psychotherapy. Explorative psychotherapy tended to become more supportive over time, and outcomes predicted were less positive than anticipated. Supportive psychotherapy outcomes however, were more positive than was expected and produced a similar effect to explorative psychodynamic psychotherapy. Earlier discouraging outcomes of studies relating to explorative or intensive psychotherapy shifted the focus and caused a retreat from considering psychodynamic psychotherapy as an alternative to other therapies. Disappointingly, there has been comparatively little recent research since the Gunderson et al. study (1984) comparing outcomes regarding the use of either insight-orientated or supportive psychodynamic psychotherapy. Supportive psychotherapy appears more popular in working

with psychosis according to Kates and Rockland (1994), not as much as an alternative to pharmacological treatment, but as a complementary treatment. This may be due to clinicians fearing that explorative psychotherapy may cause regression. While many theorists do suggest that supportive-level psychotherapy is the more appropriate choice for this client group, such as McWilliams (1994), it seems unfortunate that no recent research has been done on explorative psychodynamic psychotherapy with patients diagnosed with schizophrenia. Further study in this area might enable clinicians to provide a modified therapy that encompasses the most effective aspects of both therapeutic styles.

It is also important to note here that all of the aforementioned studies have been of a qualitative nature. Gottdierner and Haslam (2002) describe the results of past qualitative reviews on the effectiveness of individual psychotherapy for schizophrenia as being equivocal at best, as their results were based on the flawed methods of qualitative reviews. Only one published review has been of meta-analytic methodology, that of Mojtabai, Nicholson, and Carpenter (1998). Gottdierner and Haslam (2002) state that Mojtabai et al. (1998) found encouraging results in support of the effectiveness of individual psychotherapy for schizophrenia. A weakness to this review was that it was a broad one encompassing almost all forms of psychosocial treatments for schizophrenia, not one in particular. Mojtabai et al. (1998) found no evidence that psychodynamic psychotherapy was harmful, or that it was either superior or inferior to other therapeutic interventions.

Further to the meta-analytic study conducted by Mojtabai et al. (1998), Gottdierner and Haslam (2002) conducted a meta-analytic review of their own. This was the first, and to this date only, meta-analysis to specifically determine the effectiveness of individual psychotherapy for people diagnosed with schizophrenia. In Gottdierner and Haslam's review

it was found that 67% of individuals given individual psychotherapy improved, in comparison with the 34% who did not receive treatment. Cognitive-behavioural therapy and psychodynamic psychotherapy produced similar results. Furthermore, according to Gottdierner and Haslam (2002), individual psychodynamic psychotherapy proved significantly effective with or without the use of medication.

In a brief report, Gottdierner (2006) reviewed empirical evidence of the effectiveness of psychodynamic psychotherapy in the treatment of individuals with schizophrenia. It was found that "individual psychodynamic psychotherapy can play an important role in the treatment of people with schizophrenia. This opinion is based not on clinical anecdotes but on empirical research" (p. 586).

As stated earlier, there has been much controversy as to whether psychodynamic psychotherapy provides any benefit to this particular client group, with doubt being voiced by mainstream psychiatry and psychology (Lehman & Steinwachs, 1998; Mueser & Berenbaum, 1990). However, according to Gottdierner (2002), this pessimism is clearly unfounded. Meta-analytic research has shown that psychodynamic psychotherapy is associated with significant improvement with clients diagnosed with schizophrenia. Lending strength to this assertion, Gottdierner (2006) maintains that although meta-analytic reviews are not without limitations, they are the most effective way to resolve controversial findings across a body of literature.

Despite past controversy regarding the effectiveness of psychotherapy and contentious reviews, a large amount of clinical literature has accrued. Much of this literature describes those interventions of individual psychotherapists that have resulted in positive outcomes. Prominent psychotherapists who have written on this subject include Arieti (1974),

a psychiatrist regarded in his time as a foremost authority on schizophrenia; Boyer and Giovacchini (1980), classical psychoanalysts: Federn (1952), a psychologist remembered for his theories regarding ego psychology, and therapeutic treatment of psychosis: and Fromm-Reichmann (1950), a psychiatrist and psychoanalyst of whom Szalita (1981) stated: "again and again I have been told that Frieda single-handedly contributed more than any other individual to encourage all of the western world to apply psychotherapy to schizophrenics" (p. 14). Others to promote the use of psychotherapeutic techniques through published case examples include the following: Pao (1979), a psychiatrist and psychoanalyst and author of *"Schizophrenic Disorders",* Searles (1965), one of the pioneers of psychiatric medicine, who specialised in psychoanalytic treatments of schizophrenia; Sullivan (1962), a psychiatrist and psychoanalyst who became known for his experimental treatment ward for clients diagnosed with schizophrenia, Lotterman (1996), a psychiatrist and psychoanalyst who specializes in the psychotherapy of schizophrenia patients and author of *"Specific Techniques for the Psychotherapy of Schizophrenic Patient",* Laing (1960), a psychiatrist and psychotherapist, who was regarded as an important figure in the anti-psychiatry movement and who challenged the core values of a psychiatry which considered mental illness primarily of biological nature. Laing, along with several colleagues, started up a psychiatric community centre where patients and therapists lived together.

More recently, a student of Laing's, Steinman, a psychiatrist and psychodynamic psychotherapist, has written extensively of his own successful work with people diagnosed with psychotic illness.

Steinman works in an outpatient psychiatric practice combining intensive psychotherapy with measured doses of anti-psychotic medication. He describes this approach

as having been successful in helping schizophrenic patients "recover, heal and at times achieve a cure" (2009, p. xi). Some allegedly 'untreatable' clients diagnosed with schizophrenia have, through this treatment, been weaned off anti-psychotic medication, and are now leading satisfying functional lives.

Like many other writers, Steinman (2009) asserts that mainstream psychiatric literature has emphasised the efficacy of anti-psychotic medication, often leaving advocates of intensive psychodynamic psychotherapy on the defensive. He writes in *"Treating the Untreatable",* of twelve individual case studies where he provided individual intensive psychotherapy. All of these clients responded successfully to intensive therapy even though all were considered the most 'untreatable' clients in clinical terms. These case studies were only a few examples of many other successful outcomes.

It is illuminating to consider at length one of Steinman's case studies describing a woman in her mid-thirties diagnosed with chronic paranoid schizophrenia. Previously considered 'untreatable', "Mary" (not her real name) had been hospitalized several times and was, at the time of treatment, living alone in a rooming house, "unkempt, dishevelled, and clearly preoccupied and hallucinating" (p. 61). Mary had told a psychiatrist at a previous hospitalization that she had two rats gnawing at her heart. When Steinman asked Mary: "Do two rats gnawing at you mean anything to you?" (p. 62), he was quickly able to sense that the two rats had something to do with her two children. Nobody had ever asked Mary this question before. Steinman was dumbfounded that Mary was not asked about the meaning of such a strong image but no longer surprised as this was becoming a regular reply from his patients. "How can patient or psychiatrist make sense of bizarre delusions if they never discuss their possible content and meaning" (Steinman, 2009, p. 62). Mary was hospitalized

for six months after the birth of her second child. Although she felt unable to see her children during this period, Mary also felt terribly unhappy about being away from them. She both loved and missed them. Steinman talks about the delusional person finding making sense of their delusions "too much" (p. 63). If merely diagnosed and medicated, the chances of finding meaning in delusions is disregarded and the potential chance of providing more understanding of oneself is discounted.

In Steinman's account, Mary describes her mother as being critical and negative and her father as being loving and indulgent. Early memories include a ballet teacher that described Mary's dancing as coming from another world. Feeling sheltered from her father and criticized by her mother, Mary appeared to sow the seed of delusion. "When Mary was thirteen, her father died unexpectedly" (Steinman, 2009, p. 63), and this led to Mary being hospitalized for a number of months. As Mary's father had been the only stable influence during her life, she was reluctant to accept that he was no longer a part of her real life, and thus created the delusion that he was still with her. Mary created whole conversations with her father but kept her delusion a secret from others (Steinman, 2009).

Mary managed to keep herself together long enough to get married in her late teens, but her husband, a few years later after taking psychedelic drugs, hung himself. Mary, again confronted with the death of someone close to her, retreated into delusional reality. Mary married again several years later, and after giving birth to her second child, decompensated again. Steinman makes the point that "once delusional, one is always vulnerable to delusional crises and regressions" (p. 65). Mary went through intensive exploratory psychotherapy with Steinman. Over a period of six to eight months, Mary's delusional reality dissolved. Her delusional creation of her father was a risky delusion to give up as it had been

comforting. Extra measures such as hospitalization were put into place to help Mary through this period. Eventually Mary, "a previously 'untreatable' paranoid schizophrenic, had become an independent person, off antipsychotic medication, with meaningful relationships, work, and access to the meaning of her own imaginative creations" (Steinman, 2009, p. 66). This account dramatically illustrates the value of incorporating a psychotherapeutic approach with this client group.

Steinman also makes an important point regarding past evaluation of the efficacy of intensive psychodynamic psychotherapy with severe mental illness. Analyses of neurotic level clients usually last five to ten years - so why do many researchers regard two years as the magic cut off date in measuring the efficacy of therapy for the far more disturbed clients?

Using individual psychotherapy as a tool alongside other interventions has also been trialed to good effect in Finland. In 1976-1977, a Finnish national programme for the treatment and rehabilitation of schizophrenic patients was carried out. Another more recent study based on information gleaned from the first study was conducted from 1981-1987. These studies have specifically researched the individual treatment needs of patients, termed "need-adapted treatment of schizophrenic patients" (Alanen, 1990; Alanen, Lehtinen, Rakkolainen, & Aaltonen, 1991). As Alanen and his colleagues state, the earlier research carried out by Gunderson et al. (1984) is limited in that patients were randomly allocated into controlled therapeutic trials where each patient was given a different type of treatment. Case-adaptability to treatment was ignored, and there was also very little flexibility as to the possibility of any other intervention options in the therapeutic regimen; regardless of how unmotivated the patient may have felt towards the particular therapy implemented. The 1990 study by Alanen obtained promising results from implementing psychodynamically-oriented

long-term individual therapies. The approach here was based on developing empathic, and confidential therapeutic relationships. What was different in the earlier study was that, although family interaction was encouraged it lacked genuine interactionality, and that conjoint family therapies implemented were few in number and meagre in outcome. Couples therapy however, was implemented with good results.

Alanen et al. (1991) determined that:

> One of the important points that we have realized is that the treatment of schizophrenia must always be planned individually and on case-specific premises, taking into account the therapeutic needs of both the patients and the people closest to them. It is not indicated to try to treat all patients with the same psychotherapeutic method, nor are the best possible results achieved in this way. (p. 363)

The conclusion that each therapeutic task should be defined individually makes sense when we acknowledge that schizophrenic disorders are heterogeneous. As is apparent with other mental illnesses, there is a continuum of functioning and the same applies to schizophrenia. This has certainly been my experience in working with clients diagnosed with schizophrenia. Some clients have an extremely fragile sense of self, and their vulnerability to decompensation is more apparent. The use of more explorative psychodynamic psychotherapy may therefore increase the chances of decompensation. On the other hand there are clients that have a more robust sense of self and are more able to tolerate a more explorative technique. A fundamental basis to either supportive or more explorative interventions however, is the important initial forming of the therapeutic alliance.

Alanen et al.'s 1991 study comprised 31 patients entering treatment for the first time after being diagnosed with schizophrenia. Individual therapy was psychodynamically oriented but this was only one of the interventions incorporated in the study. This was generally offered at some phase of the treatment, usually when the patient brought up the

question of starting individual therapy, which is better from the motivational viewpoint than the suggestion of therapy by another. Medication was monitored and kept at a level that would interfere least with other psychosocial interventions. Family therapy was also an important intervention in this study and for those patients that were married or in a relationship, couples therapy was an option. Outcomes for this study, according to Alanen et al. (1991), showed that the integration of psychosocial along with biological interventions contributed to the reduction of psychotic symptoms, both negative and positive, avoidance of the uptake of disability pensions, and a reduction in the number of inpatient days. Psychodynamic psychotherapy was therefore found to be effective in the treatment of schizophrenia when used, as a tool, alongside other tools.

On the whole, it seems that research done on the effectiveness of psychodynamic psychotherapy with schizophrenia and psychoses has proved to be difficult and controversial. While there are significant weaknesses in previous research studies as mentioned throughout this chapter, Gottdierner and Haslam's 2002 meta-analysis study employed more valid, and reliable methods to resolve this controversy and the result of this was their conclusion that psychodynamic psychotherapy is effective in working with this client group. The work of Alanen et al. (1991) on need-adapted treatment for schizophrenia using psychodynamic psychotherapy along with other interventions is also proving promising, and offers strong support for the use of psychotherapeutic techniques as part of individual treatment plans. It is also important to note and honour the number of individual case studies that have shown the effectiveness of intensive psychodynamic psychotherapy in working with this particular client group.

Finally, I offer the words of Steinman (2009):

> I believe that you, the reader, will see that an in-depth psychodynamic exploration of delusions and schizophrenia may lead to healing and cure where psychosis and the concept of ‘untreatable’ previously reigned. (p. 33)

Chapter Eight: Conclusion

It has been a frustrating journey for me in trying to ascertain whether psychodynamic psychotherapy is effective in the treatment of schizophrenic psychoses. I have been aware of my own personal bias regarding this controversy. The majority of my clients have been diagnosed with this disorder and I continue to practice psychodynamic psychotherapy with them, supportive and explorative, dependent upon their robustness and level of functioning.

Literature around the effectiveness of psychodynamic psychotherapy has been both controversial and limited. Gottdierner (2006) states that only thirty reviews have addressed this topic in numerous ways. The one and only meta-analysis research regarding this controversy was conducted by Gottdierner and Haslam (2002). This provided empirical proof that psychodynamic psychotherapy was effective.

Effectiveness of the use of psychodynamic psychotherapy seems also variable. Many factors seem to contribute to different outcomes. These include clients' willingness to engage in therapy as opposed to being pressured into feeling what somebody else feels is beneficial to them. Other indicators of possible effectiveness of psychodynamic psychotherapy include this psychosocial intervention as a tool. Alanen's (1990) research on need-adapted treatment for individuals, promotes individualized treatment for clients with severe mental illness. The impact of this treatment sees clients not as a label but as needing tailored treatment to what clients' individual needs are.

Psychodynamic psychotherapy has been shown to be effective, with or without medication. This highlights the importance of a bio-psycho-social approach to psychosis, of developing individual treatment plans for people, and of the value of communication, and collaboration in an interdisciplinary team.

To answer my question, how effective is psychotherapy with schizophrenia and other psychoses, there seems to be no absolute answer. Has it been effective: yes, but not to all clients with schizophrenic psychoses. However, it is clear that psychotherapy should be regarded as a valid and vital treatment option for people.

Initially I leaned towards McWilliams's (1994) stance that supportive psychotherapy was the optimum treatment for schizophrenia and/or psychosis. Building defences and strengthening ego was the ideal initial outcome. After conducting my research in this particular area, my view changed. It appeared that explorative psychotherapy also had its place in the treatment of schizophrenia and psychosis. Case studies have highlighted the effectiveness of this method as described previously.

There are many aspects and variables that pre-empt different outcomes. How effective is the therapist? Are they experienced? Has a therapeutic alliance been formed? Time frames for research studies may also be important factors in determining outcome. Given the severity of mental illness it may be ideal to carry research over a larger number of years to allow the therapeutic alliance to form, and to truly determine the efficacy of treatment.

In conclusion, it is clear that it seems important that more research needs to be done to further determine the effectiveness of psychodynamic psychotherapy in the treatment of schizophrenic psychoses, and in particular the use of explorative psychotherapy. Longer time frames in ascertaining outcomes for effectiveness would also be ideal. There are still many issues that need to be explored further, to determine better quality therapeutic treatments; treatments that hopefully lead to better results enabling people with psychotic illnesses to be able to live as self-sufficient and as satisfying lives as possible.

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