

Introduction to IFPE panel: Toronto – October 2007

“How the concept of mind effects the treatment of psychosis”

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Our presentation is organized around a single case. A young lady of eighteen presented to us in a psychotic crisis, for which hospitalization was arranged. She returned to us for treatment after discharge. The outcome of our treatment effort - what we call “care in the community” – was so radically different from the outcome of the hospital’s approach to treatment as to constitute a scandal that cried out to be heard.. At least – we felt it to be so and are grateful to have this opportunity to discuss this situation – and its implications - with you in some detail.

The bare outlines of the case are as follows. During two weeks of hospitalization for psychotic mania, the young lady was heavily medicated. Her excitement was suppressed, but she remained quite delusional. Her medication-induced, near catatonic state alarmed her parents. They felt she was slipping away and were advised to demand that she be discharged. When she returned to us we met with her and her family to propose frequent meetings and a plan to reduce her medication.

She responded with a revival of her delusions and soon presented us with a management problem. We worked with her and the family to adjust her medication, while we provided daily sessions and liberal telephone access. We strove to offer a protected space and sufficient time to hear her out.

This worked temporarily, but her excitement and flightiness began to assume crisis proportions – and we had to present her with a choice of returning to the hospital or continuing to work with us – which included overcoming her objections to medication

which she had insisted on discontinuing. In addition we added another resource, to ease the burden on her family and provide more support by making trainees in psychology available to her. Their visiting her at home helped her become more self-contained. They then provided a bridge to the community by going with her in places that made her fearful. Now, after six months of treatment she is off all medication, has no psychotic symptoms and after working briefly has returned to a local community college.

To address this difference in approach to treatment, let's have a brief chat about psychosis. The question is generally posed: Why does the psychotic hallucinate and why does he have delusions? This trend in thinking sets the psychotic apart – as very different from the rest of us. There is something malignant at work in him that produces these bizarre symptoms. Long ago the psychotic was thought to be possessed by the devil.

Such belief in demonic superstition was replaced by science – which subsequently became our new God. Psychiatry – ever embarrassed at being the outcast of medicine - and a newly founded psychology rushed to embrace Science – and gain dignity. Psychiatry proudly announced the “decade of the brain” (the 1970's) and promptly “lost its mind” – thereby forfeiting any interest in the mind. Psychology became “scientific,” concentrating on behavior and cognition, and formulating standard means of controlling the psychotic's inappropriate behavior and reeducating his alleged deficiencies. This led to the development of sanctioned “protocols of evidenced based treatment” that purport to define the highest “standards of care.”

The scientific – perhaps more correctly “scientistic” – point of view deems the psychotic to suffer a “broken brain” - a genetically determined, neurophysiologic disorder that causes a biochemical imbalance that generates the symptoms of psychosis. This

perspective has converted hospital treatment of psychosis into what is tantamount to the institutionalization of malpractice. We submit as an example the blind alley of symptom control (a form of practice that medicine has always frowned upon) that marginalized our patient as an agent who thinks and speaks.

Obtunded by drugs, she came to a dead-end where only her delusion seemed alive. The treatment itself had merely replicated the malignant effect of her persecutory voices.

But there is another way of posing that same question about psychosis: “Why is it that we – us bona fide neurotics – don’t hallucinate?” Putting it this way seems to turn things on their heads. How, you may ask, can I assert that we all hallucinate? In the interest of time I will just report that current research gives evidence that the fetus can discriminate between the voices of his mother and his father: people he cannot see. Thus he must have laid down some kind of trace – some image in response to a voice beyond. And so we have a percept without an object; and this is the definition of hallucination. Furthermore, let’s be reminded that Freud repeatedly stated that the finding of an object is a re-finding of it. The point is that for all of us the first object is a hallucinated one. This first hallucination – the voice – is extraneous to the smooth physiologic functioning of the fetus. It follows that it is traumatic because it introduces something that must be responded to – it is beyond regulatory principles. Freud struggled with this concept – and wrote about it in his paper: “Beyond the pleasure principle” – where a “second death” is introduced into the organism that is beyond what is programmed genetically.

If we ask the question this way – “Why is it that we don’t hallucinate?” - we find that the neurotic has something structural that is missing in the psychotic. What is

lacking is a signifier that enables him to construct meanings to screen off hallucination, and to employ these meanings to defend against the ravages of this “second death”.

Lacan posited that the foreclosure of a fundamental signifier results in a psychotic structure. This signifier is essential to language function and its absence accounts for the disordered speech of the psychotic.

Lacan called this signifier “The Name of the Father.” to emphasize the prohibitive paternal function that limits actions and drives. The “Name of the Father” has another aspect, the paternal metaphor that enables a subject first to inscribe himself in a family and then to support his search for a position in society that enables him find at least minimal satisfaction in coexisting with his fellows.

Let’s apply these considerations to our young lady. To begin with, she presents us with a diagnostic problem. Even when excitable, flighty and floridly delusional, she did not manifest disordered speech. She was willing and able to speak to us and none of us had any difficulty understanding her.

Secondly, she was convinced that she was pregnant – which she was not - and had physical sensations of being about to deliver a child. In consequence poison gas was being piped into her room; that put her and her family at risk of death. Florid as her delusion was, it was at the same time circumscribed and confined to a small circle that centered upon her father. This is to be distinguished from the kind of delusion that has a universal quality, such as the obligation to save mankind.

Both these facts, therefore, led us to consider her not to be schizophrenic, but rather to confirm the diagnosis of psychotic mania. It shifts the emphasis away from foreclosure

of the Name of the Father – and leads to the consideration of another target of foreclosure – the phallus. According to Freud the child develops the fantasy that mother lacks a phallus as an answer the question of anatomical sexual difference. The phallus symbolizes what mother lacks, and Lacan proposes that this lack gives rise to the mother’s desire to be desired by her husband.

Now what is the fate of what is foreclosed? It is not obliterated but rather does not arrive at its destination. It instead remains in a state of unrepresented suspension within the psyche. It leaves no trace as an image, nor is it symbolized. It remains a potential like a roadside bomb in Iraq. What sets it off? When some action or some function is to be performed that would rely upon the foreclosed element – there is nothing available to respond. Instead, this suspended element – the primary hallucination becomes activated and a disembodied voice suddenly appears. The reactivated trauma sets off a catastrophe, and the subject spins out a delusion to explain what happened. What is the evidence for the lack of installation of the phallus in this case? We propose that within the young lady’s family her father’s unconscious desire was deflected from his wife onto his daughter. This was revealed, for example, when at the end of the first family session, he nodded toward his daughter, and jokingly murmured to me, “She’s an idiot.”

This discounting of his very intelligent daughter’s mind – indicated a failure to do what a father should do – foster the establishment of his daughter’s mind. By virtue of repression and along another pathway, it resulted in an unconsciously erotized focus on her body. Later on, I will detail a series of events that run like a red thread through her

history that resulted in an erotically parceled out body. Had she internalized a phallus she would have instead experienced herself as a somatic unity.

As if in restitution of this self-perceived lack, and while in the grip of her delusion that she was already beginning to doubt, she exclaimed to me: “I ate my father’s penis.” She then paused and added with a laugh: “It’s OK it was really only plastic.” We can discern the urge to incorporate what she lacked and also the regret at the artificial quality of father’s attention – that did not go toward the confirmation of her as a thinking subject.

She also claimed that she hated her father for “being weird,” and wanting to be “too close”. Thus in the absence of the “Name of the Father” and the paternal function’s limiting action, the “living breathing father” had become confused with the persecutory voice that overwhelmed her.

Our approach focused upon her mind, as we strove to meet her as the speaking subject she was. In response she spoke of what was central to her and this reanimated her delusion. Consequently it fell upon us to head off a developing crisis. To do so we employed medication as a means to temper her inner chaos. We made available trainees who could accompany her. But ultimately what worked best to limit her excitement and assuage her guilt was the gift of speech – a place where she could find the words to say it.

Let’s turn here to Dr. Boho, who will describe her experience of the young lady’s treatment.

Addendum – 1 – Contributory history:

- a – Father’s fall and injury – 6 mo/o
- b – Seizures, migraines – on Depakote 6-12yrs.
- c – Chronic ear infections – “A tube in my ear.”
- d – Antibiotic treatment for otitis – vaginal yeast infection – self-stimulation precocious production of erotogenic zone.
- e – Adolescence – acne – promiscuity.- as attempt to engage with peers – her tendency to associate with children younger than she

2 – Delusional content:

- a – “I’m pregnant and the baby is coming out.”
- b – “The baby’s arm is stuck in my throat.”
- c – “I killed someone.”
- d – “I ate my father’s penis – it was plastic.”

3 – Residual physical symptom: fainting

- a - Hypothetically – could be her body saying, “I am a fallen woman.”
- b – Medically – hypotension is demonstrated – but is this causative of fainting, or the expectable accompanying sign of psychogenic (hysterical) fainting?

4 - The economics - comparative cost of treatments:

Hospital care – 2 weeks		Community care - 6 months	
Inpatient care	\$25,725	Psychiatric fee	\$1,250
Physicians fees	2,655	Psychologist fee	1,250
		Trainee fee	500
Totals	\$28,380		\$3,000

Abstract:
Proposal for Panel Presentation
To The Eighteenth Annual IFPE Conference:

How the concept of mind effects the treatment of psychosis:
A case study with theoretical rationale.

Nowhere is the reach of the mind more important than in the way it informs psychosis - and nowhere has it been more effaced than there. How devastating the effects of this effacement can be, is the topic of our panel. Three psychoanalytically informed practitioners will discuss an integrated approach to the treatment of a young woman who presented to us in a state of acute psychotic turmoil.

A theoretical presentation, framed within a Lacanian perspective on the structure of psychosis asserts that psychoanalysis – subject to certain supports – is the treatment of choice for the psychotic. The case discussion will detail the particulars of the young woman’s delusion, relate it clinically to problems in the family structure and derive from it a clinical approach. Thus a window will be opened upon the radical difference between standard inpatient care and what can be achieved through an intensive, interpersonally rich set of interventions.

Ironically, medical care, rendered for the best of reasons: “for the good of the patient” proves to be blind to how it perpetuates the very disorder it purports to treat. The reductionistic hypothesis that the psychotic suffers from a “brain disease” – an ideology derived from the contemporary replacement of God by Science – drowns the subjectivity of the patient in an approach that attempts to control a presumed genetically determined neurophysiologic disorder by use of medication and behavioral interventions.

This has the effect of:

- 1 – reducing the status of the patient to that of an object of persecution;
- 2 – stigmatizing her as suffering from a “chemical imbalance”; and thereby
- 3- tacitly absolving her of responsibility, while she suffered from the cruelties of an uncompromising superego fragment.

This left her isolated within illness – that from the standpoint of her internalized family dynamics left her alone to face her internal representation of the “malady of the Father.” This “malady” refers to a defective “paternal metaphor” that set up a situation where her body was valued over her mind, and drove her to engage in highly erotized maniacal acting out.

The interpersonally rich treatment intervention provided a space for the psychotic young lady to speak of her madness. This space was framed by limits ranging from the judicious use of medication to confrontation with the potential consequences her choices. Where the hospital excluded the family, we welcomed their supportive availability. This was augmented by the availability of home visits made by therapists-in-training, first to relate to the young lady, and then to accompany her into the community – as she made tentative steps toward rebuilding her ruptured social linkage.

This approach averted a threatened return to the hospital from which she had been prematurely discharged (for economic rather than clinical reasons). Both confinement and expulsion had made matters worse, as the clinical picture on discharge was not much different from that on admission. The patient, overmedicated and bewildered, and the family, unable to obtain any clear information on diagnosis or treatment and desperate for help, were quite amenable to our approach.

Active discussion of her psychotic experience averted a renewed threat of re-hospitalization, and she was restored to her pre-morbid state by means of an array of interventions. Medication and revelation of her delusion helped her to regain her self-control, and enabled her to obtain distance from her madness - that she came to dismiss as “irrational thoughts.” The means of restoring her link to society was provided by personal availability of therapists in training, by our contacting her employer and by her knowledge that help was always phone call away. She began to resume her interrupted social activities, and more recently made plans to return to college.