The Common Dynamics of Psychiatry

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1999

Publisher: James P. Gustafson, M.D., Madison, Wisconsin
Paranoia comes from the Greek word, \textit{paranoia}, which means the mind (nous) beside itself (para). I think Sullivan (1956) was right to argue that paranoia is a dynamic of blaming, and that this dynamic of blaming takes many forms, from a character trait, to an obsession, to a psychosis. These variants appear in our DSM-IV as follows:

- 301.0 Paranoid Personality Disorder
- 301.20 Schizoid Personality Disorder
- 301.22 Schizotypal Personality Disorder
- 295.xx Schizophrenia
- 295.30 Paranoid Type
- 295.10 Disorganized Type
- 295.20 Catatonic Type
- 295.90 Undifferentiated Type
- 295.60 Residual Type
- 295.40 Schizophreniform Disorder
- 295.70 Schizoaffective Disorder
- 297.1 Delusional Disorder
- 298.8 Brief Psychotic Disorder
- 297.3 Shared Psychotic Disorder
- 293.xx Psychotic Disorder Due to...
- 293.81 With Delusions
- 293.82 With Hallucinations
Since some other qualities are regularly associated with blaming, we could be misled into giving them more importance than they actually have in the life of the patient. For example, many of these diagnoses have the term schiz- in them, which comes from the Greek word, schizein, to split. The splitting process splits good from bad, radically, and is prominent in all the grave psychopathology of the second half of this book, from the addictions, to the antisocials and narcissists, to the borderlines, to the negative therapeutic reactions, and to the manic-depressives.

All of these share what Melanie Klein called the paranoid position, which is the assumption that the world is out to harm you (Balint, 1952). This is to be distinguished from the depressive position, which is the assumption that the world is indifferent to you. The latter is roughly characteristic of the minor psychopathology of the first half of this book (Balint, 1952). Since surface is not always an accurate guide to depth, there are many exceptions to this general rule. Some things appear benign, but are malignant, and vice versa.

What is defining of the paranoid and schizophrenic dynamics is the blaming operation, in which there is a relatively steady hostility directed outwards against a hostile world. Compare this to the fluctuating hostility of the borderline or manic depressive or addictive or antisocial. The converse of the blame directed outwards, is the credit directed inwards. In is good, and out is bad. The world is split (schiz-) along these lines. The reader may find this paradoxical, since schizophrenics, for example, seem to have little self-regard. That is true, but what little they have is kept up by megalomanic delusions. Megalomania inwards, and paranoia outwards. This is the rough and crude
formula. The patients in the grip of this dynamic circulate around this formula, in several
different presentations.

Presentation

The obvious paranoids exude bitterness. They warn you away with those eyes,
which flash hatred, and with the body clutched away from you. It is as if you have come
to rob them. This is their premise, about any encounter.

Ruined Lives

We have many patients in the clinic whose sole discourse is that doctors have
ruined their lives. This is what little identity they have. This is a variant of a wider
category of blaming the world. Freud's famous Schreber case (1911) was of a judge in a
state supreme court, who blamed God for invading his body and destroying it. Thus, it is
possible to blame doctors, God, the University, the company, the family, and so forth and
so forth. This identity of the ruined life, and its discourse of blame, can be extended ad
infinitum, to fill up all of time and space.

The Case of the Victim of Doctors and her Absorbent Psychiatrist. I met this
woman in her teens, when she complained of an irritable bowel. She blamed her doctors,
for not fixing it. They sent her to me. I noticed her bitter satisfaction at pinning the
blame on the doctors, but I also noticed that she did suffer from her condition.

She had little else to talk about. Her family was dispersed. Her friends were
negligible. Her work was part time. She was too exhausted to do any more.
Her two chief hopes were in going west, where she thought things were much better, and in getting on disability. She got the latter, as she was too afraid to go anywhere else.

I listened to her twice a month for about a year, when she began to complain of the uselessness of visiting me. Nothing ever changed. Didn’t I have any therapeutic ideas? I believed she got a little out of having me as an audience, but my value depreciated over time. She finally trailed off, emitting occasional remarks that I wasn’t of any use.

I ran into her in the clinic several years later, when I opened the door of one of the residents’ offices. There she was the same as ever. She grudgingly acknowledged that she knew me, and turned to the resident to resume her bitter monologue. Later, the resident came to ask me how he might help her more? I laughed and inquired what gave him the idea that she could improve?

He explained she hoped to get over her pain. I asked how that was going to happen? He admitted she was looking for some kind of miracle. She would hear of this or that drug, and rise a little, and soon be bitter again. I said, yes, it is completely circular, from false hopes, to blame. Then, it starts over again. He had already been around this circle with her ten or twenty times, so he knew exactly what I meant. So why does she come then, he inquired? I said she must be getting something out of expressing herself. “Yes,” he said, “with the absorbent doctor,” and laughed! I thought that that was a marvelously accurate phrase, for what he was doing for her. She exudes bitterness, and the absorbent doctor soaks it up!
I have noticed that we have many residents who are good at being absorbent doctors for bitter patients. They have enough naive faith, that they can soak up quite a lot. It takes a while to fill up their absorbent containers, and the patient gets some mileage out of it in the meanwhile.

Malignant Paranoid Regression

The second common paranoid presentation in the clinic is a little more subtle, for the interviews can start off all right. However, the more the terrible history is told, the more the patient becomes afraid of relying on the mercy of the doctor. He feels at a greater disadvantage the more kind the doctor. He is pulled into depending upon him, and becomes acutely anxious that he will soon be betrayed (Sullivan, 1956). Suddenly, he turns accusingly, and the doctor is completely shaken by the hatred visited upon his taking pains to get a good history.

The Case of the Girl with the Motorcycle Gang. By the time this woman came to the clinic, she was no longer the girl that had been gang raped twice. Now she had raised the daughter conceived in the second rape, and was a leader in the ladies’ motorcycle repair club! She was identified with her persecutors. However, she slept poorly, because of nightmares.

The resident was painstaking, and wanted an accurate history, but the more she told of it the more she came apart. Finally, she turned on the resident, refusing to sign the release of information to her primary care doctor. She left in a hostile fashion.

The resident was somewhat in shock from this experience. He had only been doing his job, and look what happened! Yes, I said, this is what happens sometimes
when you take a history. Malan (1979, Chapters 21 and 22) found to his own chagrin that taking histories can be dangerous for the patient and for the doctor. If the patient has been barely containing nightmarish material, she might not be able to put it back in the box once it has been drawn out! The patient who was functional at the beginning of the interview is in a psychosis by the end of the interview, that is, in a nightmare from which she cannot awake (Sullivan, 1956).

The paranoid turn in the interview is an attempt to externalize the nightmare by blaming the doctor for eliciting it, and then fleeing from him. This often gets the patient out of the potential psychosis brought on by the interview. This is why it is not a good idea to go rushing after these patients to get them to come back! This makes the doctor even more dangerous than he has been already! and could lead to physical violence (Ebert, 1987).

**In-the-Corner Lifestyle**

The third common paranoid presentation in the clinic is the paranoid patient who feels he has to live on the margin of society. Jones (1923) noted that the patient who believes he is God is likely to live out of town, because there are fewer disconfirmations of His Existence. White (1989) noted that the same result can be achieved living in town if you live in the corner. Beels (1991) noted that boarding houses are the most stabilizing places for these patients, because they can avoid everyone when they want to, but find somebody up late at night if they need a little company.

I summarized all of this (Gustafson, 1995a, Chapter 1) as the near/far dilemma in its extreme form. Farness is the best defense against fellow human beings, but it leaves
you at the mercy of your own introjected aggressors, in the form of persecuting voices. Thus, the patient comes toward his fellows when he is persecuted from the inside. This gives him a little comfort from the outside, until he feels at the mercy of his comfort, so he feels persecuted from the outside. Thus, he retreats again. This is the natural circularity within the paranoid dynamic (Gustafson, 1967).

A Case of Successful Adjustment to the Paranoid Cycle. This young man was an alcoholic, until a psychiatrist realized that he was very paranoid, and got him on risperidone, instead of alcohol. This worked better to calm him down. Also, it helped that he could get a job in one of the halfway houses as a maintenance man. There he pursues his work keeping order.

This works relatively well, because he is proud of his contribution, but can distance everyone as he needs to, by picking up his mop and pail. What threatens him is his boss. The previous boss dealt with him fairly, but the new boss has been arbitrary, to show his authority. This has shaken our patient, with helpless anger. So far he is hoping this phase will pass, and the guy will let him alone. He is keeping away from him as much as possible.

History

Many observers since Kraepelin have noticed that paranoid psychosis is most likely to emerge in the transitions from high school, or college in young people. Now why should that be so? Evidently, the patient has some security in the earlier phase of development, which is lost in going on to the next phase. The identity collapses in reality (James, 1902), and emerges in a restitution (Freud, 1911) in a megalomanic identity. The
center cannot hold, and the archetypal belief that one is God, or Jesus Christ, or the equivalent, occupies center stage.

Now it is true that most or many young people who have an identity in high school confirmed by a peer group and family and church and school have this identity disconfirmed in college, in the army, in a job. Suddenly, one is just another guy, in a degrading fraternity, in boot camp, or in a fast food kitchen. Certainly, this shakes confidence, or even takes it away. These total institutions (Goffman, 1961) could be said to be designed to cancel the previous identity, in order to shape a new identity, as pledge brother, or army brother, or as proletarian laborer. The individual is humbled, to take his place in an adult world in which he is pledged (Sartre, 1960; Laing and Cooper, 1964) to be like everybody else, as one in a series getting on a bus, or as one pledged to fighting the same fight.

Most people can undergo this canceling of individual identity without having to have a psychotic restitution of identity as God. They probably split the world, between private where they can be more themselves, and public where they have to be in role. Some young people cannot undergo this passage into adulthood. Why is this? and what happens in place of the ordinary rites of passage?

Reider (1953) (Gustafson, 1995a, Chapter 1) argued that paranoia in the negative sense of being persecuted by the world is always preceded by what he called positive paranoia which he said was the delusion that the world is out to help you! In other words, patients from desperate family situations will often idealize teachers or neighbors or grandparents to keep up hope in a world that could be kind to them. This gets them through hopeless situations in childhood (Werner, 1989). This idealization works just
well enough to give a little security with the high school English teacher, who approves of the patient's ability to write, or with the scoutmaster, who is glad to teach the skills of scouting.

When the patient leaves this region of childhood security for the totalizing institutions which will make him like everybody else, the disappointment is too crushing (O'Brien, 1958; Bateson, 1962). He falls back into the nightmare of early childhood, and into the despair that no one can be trusted. From the positive paranoia that the world is out to help you, he turns to the negative paranoia that the world is out to harm you.

The final event before the psychosis is often the collapse with a girlfriend or boyfriend. The patient has pinned his last hope on trusting a girl or boy who is idealized as out to help him, and she or he turns out to be selfish, or more interested in somebody else, or even cruel. This cancels the last hope in reality, and the patient begins to hallucinate God as the hope of the psychosis.

Sham and Mystification

Laing (1959) has a more complicated account of the transition into psychosis. The idea is that the patient feels so vulnerable to being made into a thing that he makes himself into a thing to reduce the painfulness of the treatment by others by taking charge of it himself. He becomes a false self. However, he feels more and more dead. He feels like his body is not him. Finally, the psychosis erupts into this dead space, when the patient is taken with a girl, or a cause, or some other claim to being alive again. The excitement takes a megalomaniac form.
Laing’s account is consistent with several accounts of the danger of growing up in sham (Henry, 1973; Bateson, 1972). One version of this is the double-bind hypothesis (Bateson, 1972) in which a family speaks of love, while enacting hate, and refusing any discussion of the contradiction between the verbal claims and the nonverbal reality. This weakens the child’s ability to sort out idealizations, when they prove disappointing. The ideal claims to be ideal, while the young person feels it to be false, but is trained to ignore his own feeling. Thus, he goes numb, and makes himself a thing, and can eventually feel dead.

Laing (1965) argued that the double-bind is only one version of a larger set of activities which confuse the patient so that he cannot sort out the ideal from the actual, the good from the bad, his own feelings from what others want him to feel for their security. He borrowed the term from Marx called mystification which means

a plausible misrepresentation of what is going on (process)

or what is being done (praxis) in the service of the interests

of one socioeconomic class (the exploiters) over or against

another class (the exploited) . . (p. 343)

Laing argued that this goes on in pathological families, which confuse their children’s interests (the exploited) with their parents’ interests (the exploiters). The security of the parents is perverse for the children, when the children become muddled, befuddled, clouded about their own feelings, thoughts, and interests.

This mystification is achieved by two operations. One is to disconfirm the content of what somebody feels, thinks or believes. “You don’t really feel, think or
believe that, do you dear?” is the standard maneuver. The second mode of mystification is to confirm the content of an experience, while disconfirming its modality.

Thus, if there is a contradiction between two persons’ perceptions, the one person tells the other, “It is just your imagination,” that is, there is an attempt to forestall or resolve a contradiction, a clash, an incomparability by transposing one person’s experiential modality from perception to imagination or from memory of a perception to the memory of a dream (“You must have dreamt it”). (p. 345)

Nowadays, the most common form of the mystification of modality is to say to the person or patient, “Yes, you feel anxious or depressed, but it is really your illness” (transposing modality from feeling mode to illness mode). This invalidates the feeling as a valid signal of what is actually going on in a situation. It has become merely a sign of a distorting illness.

A great deal of work in the fifties and sixties with families argued for this mystification (and related concepts) as the mechanism for bringing about a paranoid psychosis in acute form, or in the chronic form of schizophrenia. More recently, Selvini Palazzoli et al. (1989) introduced a more sophisticated form of the mechanism in their hypothesis of the imbroglio:

Imbroglio, then, is a complex interactive process that appears to arise and develop around the specific behavior tactics one of the parents brings into play. It consists of bestowing a semblance of privilege and preference upon a dyadic transgenerational
(parent-offspring) relationship, when, in reality, this professed rapport is a sham: It is not grounded in genuine affection and is nothing but a strategic device used against someone else—generally the other parent. (p. 68)

For example, a father pretends that his daughter is his favorite confidante, to get back at his wife. When the girl begins to get out of hand in adolescence, the father reneges on the sham. His lot is with his wife, and the girl is enraged, and bewildered, by his betrayal. She escalates. This can take her all the way into a psychotic claim, as restitution for being robbed of a claim in reality.

The chief weakness of these variants of mystification is that many families have many degrees of mystification, without any of the children becoming psychotic. They may become borderline, or very shaky obsessionals. Constitution seems to have a role in how able the children are to hold onto their own senses (Werner, 1989). The surrounding environment also has a role, for the children who go out the back door of disturbed families, to make it to a neighboring family, or aunt and uncle, or to a friendly schoolteacher, do much better than the children who sit still in the middle of the disturbed family (Werner, 1989). Constitution and neighboring possibilities work together, because the more vigorous children seem to insist on getting what they need outside the family.

The Case of the Paranoid Son. I have seen this young man for several years, about twice a month, over his struggles with his parents and sister. He is obsessional in his studies at the university, and relatively isolated. His chief complaint has been that he is devastated every time he goes home.
For a long time, he has been baffled by what happens when he visits. He knows
that his father is a tyrant CEO, who rules every detail. He is not allowed to shovel the
sidewalk in the wrong order, or leave the garage door open. He knows this. This is
painful enough, to be shouted at over a minor infringement.

Gradually, he has come to see that his mother is much more dangerous than his
father. The father is obvious. The mother is mystifying. She begs him to stay as long as
possible, while acting mortally wounded if he should not comply with her. Father then
attacks him, for upsetting mother. Sister plays a game parallel to mother.

Recently, he told them he would only visit for a half day, and got no reply. They
do not tolerate any compromises of this kind. Either he has to come home and be
swallowed up, or he is to stay away. This is a version of what Wynne et al. (1958) called
"pseudo-mutuality." Its chief defense is what they called the "rubber fence," which lets
nothing in, and nothing out!

Wynne et al. argued that this is a mechanism of schizophrenia. That is possible,
but it is also a mechanism for reducing confidence in general, with varying results of
psychopathology. The sister who sits in the middle of this family is borderline, and has
been grossly malfunctional. Her brother, my patient, has been able to work as a graduate
student, howbeit in a narrow, obsessional mode. He is more functional, I think, because
he has been able to go out the back door, and get confirmation of the machine he is up
against. He has kept his distance, to keep from being destroyed altogether.

Still, he is very guilty about staying away, and he is highly subject to amazement
that they could be doing this to him. He is also somewhat paranoid. For the first year, I
could hardly say anything to him without his getting it distorted. By the second year, he
has been able to see that he has treated me as he has been treated by his family. I was not allowed to say anything, without being invalidated. Neither was he.

Change

There are all degrees of paranoia, and the lesser degrees can be reduced more readily. I will cite the three common changes that I am able to bring about in the clinic.

The Case of Giving Bad News. A friend of mine is a medical doctor in oncology, in which things often turn out badly. Thus, he is continually having to explain why things went wrong. He is a very earnest and hard-working and talented doctor, so it is very hard on him when he is blamed.

For years I have been explaining the paranoid dynamic to him, and its implications for giving bad news. For years, he has suffered some pretty awful meetings with paranoid patients. He would be especially nice to them, noticing their touchiness, and get dealt back the most ruthless attacks. I would remind him of Sullivan’s (1956) explanation, of why you have to be very matter of fact with paranoid patients, and more unpleasant than nice, so they won’t think you are trying to disarm them and take advantage of them. You ought not to try too hard, or you will arouse their anxiety, and then their suspicions.

He called me recently to say that he had had two difficult meetings with families about their patient, and one had gone badly, and one well. He told me about all his efforts to communicate with the first family, and how the session had gone from bad to worse. The more he explained, the more he was cross-examined. Yes, I said, and what
did you do with the second family? He said he made it as brief as possible, and nothing bad happened.

The Case of Sudden Paranoia in the Transference. I have a number of patients who can go along all right with me, until I say one sentence that is wrong and the patients are shaky and sleepless for weeks! I have set off a paranoid episode, by an unwitting remark.

It is a tense situation when the patient comes for his next session, and I have to find out what it was I said, and how he misconstrued it. Following Sullivan’s line (1956), I am never too nice about it, and simply try to get the detail exactly as he heard it, and exactly what conclusion he drew from it. Then I can put the thing to rest, relatively quickly. Generalities and vagueness are bad in this situation. They prolong the suspicion, and even make it worse. When you are accused, get the evidence out on the table.

For example, I said to a patient near the end of an hour that he was getting much better. Later, I found that he thought I meant he should stop therapy with me. For example, I also said to this patient at another time that work was hard on him. Later, I found that he thought I meant that he should be stronger in tolerating it. Either an abandonment or a critical intrusion (Balint, 1968) suddenly opens up from a misphrasing of something meant as a matter of fact. The patient finds himself in an old abyss, and feels betrayed into it by me! He is in quite a paranoid state. Getting this straightened out is a very big thing for this patient. In most of his life, such misunderstandings led to breaking up of friendships, or long periods of alienation from his wife. If he will continue to circulate between a shaky trust and paranoid betrayal, he will recover faster
by getting through a number of them with me. Winnicott (1947) used to say that his mistakes were the most useful things, because they gave the patient the opportunity to repair something drastically wrong between himself and a key person in his life.

**The Case of Grand Claims.** This young woman is always telling me how marvelous things are, while giving me a beady eye, and conducting me like an orchestra with her hands high in the air. I am to be as mystified as she is, evidently. I usually go along with this for most of the hour simply because she will become exasperated if I object. I wait until she finally asks me what I think, always very late in the hour. She has to have her monologue first.

She is treating me as she was treated as a child. She is turning what she suffered passively into an active imposition upon me (Weiss and Sampson, 1986). This is also called projective identification (Klein, 1959), for she forces me to identify with her position as a child. My job is to show her how to handle it. I wait, because these fragile overpowering people cannot be contradicted straight off. I am always given my chance to introduce something she left out. Yes, her friend is marvelous, but unlikely to give her a job.

**Blame and Mystification**

These three brief cases illustrate the circularity of blame and mystification, mystification and blame. The patients were mystified as children, like my patient who was lectured about how great everything is supposed to be, when having to listen to such a lecture is a kind of torture. The content is belied by the procedure. Yet, the patient is not allowed to object, without being crudely blamed. The parent was so fragile, that the
patient had to sit stock still. The domination by tyrants who are fragile sets up a cycle, which circulates between uneasy monologue, and betrayal by the listener, who is severely blamed.

I do not mean to say, as Laing seems to say, that these patients are innocents who are ruined by their parents. That is itself a kind of paranoid way of looking at the history. Actually, the patients try out these very procedures of mystification by monologue, and severe blame for minor misphrasing, on other people, including us! They torture us, over nothing. We had better be ready for them, or we will suffer too much. Objective hatred (Winnicott, 1947) of paranoia is such an excellent thing. We are not mystified by it, we weather it, and we get the facts clarified. We get out of being blamed. The patients thus learn by watching us.
Laing (1959) liked to emphasize that a psychosis usually erupts out of an untenable situation. By this word, "untenable," he meant that the situation cannot be grasped by the patient. It is so contradictory, like a double-bind, or an imbroglio, or any other mystification. I will show that this is common, and largely overlooked by doctors, who tend to think that the patient is ill, and in needing of correction for his distortions.

I think it is also true that patients have mad projects which are untenable, and eventually collapse. I am not saying that they are ill, although they appear to become ill, but rather that they expect to perform miracles like Joan of Arc. Grand campaigns of this sort do not last very long in the world, before their special conditions are no longer tenable.

In other words, a person can be disconfirmed in a terrible way either because his aims are too high for reality, or because reality is too decimating for quite ordinary aims. When an identity is disconfirmed, it may fall apart. Then, an archetypal identity with God is dreamt, and the patient cannot wake up from his dream (James, 1902; Freud, 1911; Sullivan, 1956; Gustafson, 1967).

This complication of the paranoid dynamic into psychosis may or may not be reversible. Often it is not. We shall see what holds it in place. Sometimes it is reversible. Few doctors know any more how to bring about a return from a psychotic dream, so I will give that technical matter a greater emphasis. Mostly, a grasp of this complication will only help the doctor do more modest things, which help the patient feel
a little understood by his doctor in a world which fails to understand him at all and only considers him crazy.

Presentation

There is a bipolar element in this dynamic, between the megalomanic good and the diabolic evil. However, the patient mystifies the two poles, making them difficult to distinguish, and himself completely confused, and terrified. It is truly a waking nightmare when you cannot tell friend from foe.

The Case of Sherman. A classic and commonplace example of this chronic paranoid schizophrenia is taken from my thesis at Harvard Medical School (Gustafson, 1967).

The patient was first admitted to a mental hospital in 1948, at the age of 21. He was brought by his step-father, who complained that the patient had been engaged in bizarre solitary religious rituals for about six weeks, the onset being in some relation to his mother’s going to California to care for a sick brother. The mental status exam includes the report that “He says he is Jesus Christ” and that “He has Jesus with him” and that he attacked a patient and yelled at him, “Begone Satan!” He has had numerous other admissions since then to various hospitals. Except for one brief period, the time outside the hospital has been spent living at home. The usual circumstances for re-admission have been that he loses his job, hangs around the house, and then gets violent with one of the parents.

This patient’s experience of phantoms seems to be somewhat different than the other five cases in that it is intermittent and more visual than auditory. In
those respects, it parallels the religious cases of William James. It is different from them in that the patient does not succeed in being converted. He doesn’t make it as a Saint, and he does very poorly as a Creature. The patient is a convert manqué!

The data was gathered from six interviews with him over the period of a month and the additional use of a diary. It is more historical and less contemporary than the other cases necessarily because of the intermittent nature of the experience. The diary describes the onset of hallucination—which he tells me was about six years ago - in the opening passage:

“The proof has been presented to me, of the true existence of God. He will help those in need of him. How do I know? He has helped me and I’m sure he will again!”

“The first time I heard and felt the existence of people on the spiritual plane was when I had been pounding the brass key for code practice. I had just suddenly found myself aware of the ethereal—within myself. My apologizing for breaking in (or interrupting) a club conversation was enough for one girl to break in and make me aware of the two worlds. I didn’t follow up and talk with her—the situation was unique. I just listened and tried to make better contact, but it remained up to this girl to better the situation. I couldn’t have done any more at this time.” (quoted as written)

He explained to me in our next interview about “the interruption of the club conversation.” His mother’s bridge club was meeting in the kitchen, while he was practicing Morse code in his room. He went on to say that the voices had
made contact while he tapped the key (perhaps a different occasion at the key, he wasn’t sure) and told him that they were “a million miles away” and that he would “join them when I die.” “Contact” was thus made six years ago. The onset of definite voices, he dates from only six months ago, when the phantoms tested him with a machine, which allegedly repeated the phrase, “You’re evil,” and then instructed him to listen carefully to other people.

Several of the visionary experiences, like the initial contact, appear to have been initiated by experiences with women. For example, he related the following story:

There was a girl in the apartment above that of his family, whom he had never met, but whose father he was acquainted with. One evening, while watching “The Jimmy Durante Show” on TV, and while laughing, he was surprised to hear her laughing also at the same program in the apartment above. He was very impressed by this “natural” contact, and soon after had the following vision: Namely that the devil told her he was going to take her down to Hell, “that the devil tried to separate us.” “But,” he commented, “I knew what to do then. I made a circle around him and he went down into the darkness.” When did this occur? “No exact time.” You mean it was eternal? “Yes.”

Nearly all of the visions are related to some drama about going down with the Devil or going up with God (in fact, that’s how, roughly, he defines God and the Devil, by their direction!). I will give several more examples:
He relates that on one occasion he “penetrated into the heavens.” “The angels offered to help me make a circle around the earth.” “Someone brought my soul back.”

“God sold me to the Devil. Then he learned more about me and brought me back.” What does God want you to do? “He gave me the power to cleanse. I lost it to another man on R3, because I didn’t deserve it.” “I cleansed two imps down there—put halos over their heads.”

The other entry in the diary is similar material:

“When I realized the danger of the visions I had, I grew frightened and silent within.”

“I became frantic when I had the scene of my heavenly choir become fallen to the evil entities about us. While they (a) were still with me, my field of perception grew to encompass the darkness within me. Below, this field I actually saw the form of a witch and then heard her (in a broken voice) say ‘and then the tower of Babel.’ I couldn’t understand this. it was said after she actually cackled (laughed).” (In the margin is the following footnote) “(a) the choir—those who stayed with me after others left. As they fell, they sang ‘a World Savior.’”

The hypotheses raised by William James (1902) concerning successful conversion and the factors that were brought out in the O’Brien (1958) case led me to ask the patient some direct questions in the last two interviews. It seemed from the preceding data that the patient had differentiated two phantoms, namely God and the Devil, and vaguely defined a problem of avoiding the Devil. He did not appear to be making a very active choice between them or doing any fighting
for his salvation—he seemed to have been very passive in the struggle. Nor did he seem to have developed either of the other reality-orienting operations, namely, adjusting his visions to a social context or finding a mode of expression. I had asked him why he hadn’t told other people about God’s greatness. He replied: “I didn’t have to. It was obvious looking at me. (To whom?) the people around me in town.”

It seemed to me in talking with him that his differentiation of God and the Devil and his definition of the Problem of Salvation were very weak—probably a very shallow introjection of another person’s intellectual views. I was thus led to question him about these matters in our last two short interviews, which I will quote roughly from notes:

I: Are God and the Devil distinct?

P: Yes.

I: How are they distinct?

P: In appearance. I saw them once.

I: Would you tell me about that?

P: No. I can’t.

I: Are they different in behavior?

P: Yes.

I: Tell me about that.

P: They both have their jobs to do.

I: Are God and the Devil alike then?

P: No, keep them apart.
I: How are they different?

P: The devils are more treacherous.

I: Does God ever become like the Devil?

P: No.

I: You said that you had to keep them apart yourself.

P: No, they keep apart themselves. One time when I was rising, the devil threw a pitchfork at me. I felt it.

I: Where?

P: In the lower extremities.

I: In the legs?

P: No, here in the back (pointing to his low back) . . . Sometimes they could work together. But the devils are too treacherous . . . The devil wanted power. I had power once. God sold me to the devil.

Then he took me back.

(last interview)

I: Where do you stand now, with God and the Devil?

P: Well, I got out of Hell. The Devil pushed me out. I felt it from below. He said I was brilliant. He made me come up very fast.

I: Is that like the Devil? Isn’t he treacherous?

P: Well, that’s what a friend told me, that he was. He tried to help me out with this. I know they work together. Each has his job to do . . . I was in the caverns. I told him what I wanted.

I: What was that?
P: (Patient reluctant to tell it, agrees to) Pardon for all the Jews of this world. Then I blacked out.

I: Can you tell me any more about it?

P: I don’t want to think of it. I want to stay on the plane of activity..

It all sounds so silly.

I: What about going up with God?

P: Yes, once, I penetrated into the stars. It was very enjoyable, watching the stars go past. Then someone saved me. I was brilliant.

I: Did you keep going?

P: I got lost. I hoped to make a complete circle around the earth to the starting point.

I: Saved? Who was it, God or the Devil?

P: (condescendingly) It doesn’t have to be one of them. It was the police.

I: Oh, the police?

P: Yes, they’re to protect people . . . There are lots of different kinds of God and kinds of devils.

I: Oh?

P: I can’t talk about that.

I: Why not?

P: They hear everything I say. They can watch the position of our bodies from down there. I can’t say any more.
I: You have another block? I think you can get beyond it.

P: Is it good to go beyond them? You would think so, with your interest in research, but I don't. I'm afraid I'll go down there.

Every time I was there I was blocked.

I: Are you afraid to... afraid you might want to go there.

P: I want to stay on the plane of activity.

P: I can't tell any more. Can't tell anyone... It's about my destiny, these are personal things. It's in doubt. I know I have another life, that I've been told.

I: But if it's in doubt, perhaps you need some help.

P: I can't trust anyone.”

God and the Devil appear to be Operators who are hardly distinguishable: God sells the patient to the Devil, the Devil pushes the patient out of hell—the usual roles are confused. Hell seems to have some attractions; penetrating the heavens appear to be fearful. One has to be “saved” from it by a policeman. God and the Devil are said to work together; and when asked if they are alike, the patient says, “No, I keep them apart.” Furthermore, he tells that it was a friend who told him the Devil was treacherous.

What we have left to differentiate God and the Devil is that they are allegedly different in appearance—and that God is generally up and the Devil is generally down (with some exceptions)—another visual distinction. So it appears that the first of the basic functions necessary for recovery, i.e., differentiation of the phantoms, is so weakly carried out that the acts of choosing and fighting are
quite impossible. As for the reality-orienting operations, the patient’s situation appears to be the following: He has not been able to define a problem within the hallucinatory world, relate the visions to a social (church) group or find a mode of expression (until the abortive diary he began for me). What he has done (with the doctor’s help) is to define the problem of choosing either the whole hallucinatory sphere (the ethereal plane) or the outside world (plane of activity). He never really solves the problem, moving back from the one to the other over the years as he finds one more intolerable or preferable than the other, “reality-testing,” as we say, the benefits of one world against the other world.

The patients can get out of their muddled condition by resorting to a very crude paranoid boundary. The megalomaniac pole is within, and the enemy is without. Thus, this patient identified himself as Jesus, and his neighbor as Satan. However, the crude polarity which elevates the patient and blames the world is always about to fall apart. God and the Devil act the same.

**History**

The other seven cases of chronic paranoid schizophrenia I studied for my thesis had the same befuddlement about the poles of good and evil. They varied in their stance towards this confusion. Some claimed that the hallucinated voices are all for the good, while others claimed that they were tortured by them. In actual practice, the voices were completely mixed up, between blessing and torturing the patient. Yet the patient was almost completely unable to sort out help from harm. He would always take a blanket
attitude, for or against. Sometimes, he would admit that the voices started off as friendly, and became nasty soon after. Sometimes, he would insist they were one way all along.

The histories were all about the same. Either the patient got in an untenable situation, which crushed his identity, or he made untenable claims of ordinary situations, which also crushed his identity. Often, it was a mixture of harsh circumstances and grandiose claims, but all proportions work out about the same, since the patient is disconfirmed either way.

The Center Cannot Hold

The history is always the same with these variations. The identity collapses, when put in circumstances which disconfirm its claims. Then, the patient tunes into God, and becomes Him, or his Agent. I had no access to a reading of the family dynamics in any of these cases, since my interviews came long after the catastrophe of the psychosis. I could not gauge how mystified the patient was by his own family, before he became completely mystified by the world.

I am now inclined to think that most of them were confused by their own families, before the world confused them. I base this hypothesis on several converging lines of evidence. First, there are some case reports, which document the parallel structure of the patient’s confusion with his family, and then later with the world (Cameron, 1961; Schatzman, 1963; Laing & Esterson, 1964). Secondly, there is the remarkable and consistent structure of the hallucinatory world in all of my cases, in which the patient is unable to make up his mind about anything of importance to him. Thirdly, there is the remarkable improvement that some patients can show when a doctor comes along who
can help the patient sort out help from harm (Cameron, 1961), or when the patient can get such help from a religious movement (James, 1902), or when the patient manages to do it for himself, by deciding which aspects of the voices are helpful and which are harmful (O’Brien, 1958; Bateson, 1962).

Finally, I have more recently had the opportunity to see patients in acute psychotic breakdowns, and see them with their families, and make my own assessment of just how mystifying these families were for their children, and just how much I could relieve the psychosis, by clarifying the difference between harm and help from the family itself. I will come to this matter of change in the final section of this chapter.

I want to be very clear that I am not arguing that all psychoses are preceded by a confusion in the family, which sets up the confusion with the world along the same lines. I am simply arguing that it is commonly overlooked by doctors who have little or no knowledge of the possibility. The gap in such a history is not going to be supplied by the families voluntarily, for they are already feeling frightened and guilty and ashamed. They are going to want to blame something or someone else, and not themselves. They can be very practiced at providing a smooth surface to the world that hides all conflict between them (Selvini-Palazzoli et al., 1989).

I am pointing to a terribly crucial matter in the history of a young person, whose identity is disconfirmed by the world. Can he sort what is helpful about the world’s response, versus harmful? If he can, he can retain some of his identity, and revise some of his identity. The crisis need not become a catastrophe, so long as he can sort out his value from his errors, and the value of the world in judging him, and its errors.
Before we turn to this possibility of change, it may be useful to see what its opposite looks like, in the most extreme case I have ever seen of a complete lack of a seat of judgment in the patient. As I have already said, all of these patients that I studied were relatively passive, and wholly one-sided in their appraisals of what the voices told them. If they had been like that with their families, and with the world, they would have been easy marks, and completely disconfirmed. Notice the savagery of the disconfirmation in this case of Roger, who was remarkable for shouting out whatever his voices said to him. He had been reduced to being their mouthpiece!

The Case of Roger:

This is the most bizarre and, I believe, the most interesting of the six cases of chronic hallucinoia. For the patient does not merely hear the phantoms within himself. Rather he speaks and shouts out what they are saying—making him say—and also speaks aloud his own answers to them. He gives us a remarkable opportunity to observe the phantoms directly.

The past history of this patient is largely unknown: The state hospital records indicate that he was admitted briefly in 1947 at the age of 26, again briefly in 1949, and then continuously since 1950 for the past 16 years.

There is little other information aside from the fact that he has exhibited various gyrations of the hands and has been withdrawn. There was some suspicion of a neurological syndrome because of wasting of the hands and questionable reflexes, but this has not amounted to anything apparently. No social history was taken. I learned a bit more from the patient himself. The family consisted of the patient, his brother a few years older, his mother and his
father who was a businessman. At age 8, the family went to Europe. At age 10, his father died. He went to a well-known private school for boys and then went on to a famous technological school while living at home. He studied marine engineering for two years before he was taken to the state hospital, where he has remained for twenty years, -- his mother visiting him regularly twice a week.

I have seen this patient in eight interviews over the course of a month and a half. Two of the last interviews were tape-recorded and provide most of the following data. It is difficult to capture on typescript the alterations of personality that sweep across this man. As a different phantom speaks through him, there are not only different words, but striking changes in tone of voice, facial expression and gestures—as though the phantom takes over his whole body. As far as possible I have indicated these changes in parentheses. I have also placed my own questions in parentheses.

The first excerpt demonstrates the three phantoms that I have encountered:

(Well, we can stop for today.)

Don’t see him anymore (snarling).

(Why not?)

I don’t think I want to see you anymore (firmly).

(Why is that?)

He’s Russian. Yah? Yes (snarling)

It’s all right (firmly)

I just don’t want to have anything to say . . . talk about anymore . . . tell you any more (firmly)
All right . . . tell him about that? Should I? (meekly)

No. (firmly)

(Why?)

Because you have enough information now (firmly)

(To do what?)

That's what I'd like to know. I don't know what your purpose is.

(firmly)

The phantom that one attempts to converse with is reasonable, firm, definite ("That's what I'd like to know . . ."). We will refer to this phantom henceforth as Definite. The interruptions are made by a harsh, snarling phantom which is always on the attack. Occasionally its interruptions are not so loud, but they are always punitive ("Don't see him anymore."). We will refer to this phantom as Attack. The third phantom is always soft-spoken, smiling and deferent ("Should I tell him about that?"). This phantom we will refer to as Meek.

In the previous transcript, I have referred to the three phantoms without taking notice whether the phantom spoke as a separate entity to the patient or whether the patient identified himself with the phantom. In the following script we will follow these shifts in two examples of identification: first the phantom speaks to the patient; then the patient adopts the tone and message of the phantom and speaks to the interviewer:

You'd better talk about the voices in your head (Attack—surly)

(Why?)

They talked quite a lot yesterday (self—also attacking)
You couldn’t sleep (Attack) No. (meekly) They talked quite a while at night (Attack) In the afternoon too.

(Yes?)

No, they weren’t

(So you thought you’d better . . . ?)

. . . She was here (referring to his mother)

That’s right. (surly again)

Hmm. (Meek)

Better not (Definite)

Maybe I shouldn’t. (self—also definite) I went out to the canteen this morning. Couldn’t do much else this morning. It was too late to work.

The following passage demonstrates both an identification and another apparent pattern—that is, the expression of the Meek phantom towards the interviewer, or the gratification of the Meek phantom, usually is followed by a severe Attack:

I can’t give you a story of my past, don’t know much about it.

(You seem to know quite a bit about it).

Some of it but not . . .

(It seems to come back in snatches).

Not much (Definite)

(It seems like quite a bit to me)

Think so? (meek)

Went to school in Boston (Definite). (The patient actually went to school
in Brookline).

I did (Meek)

In Boston high school (Definite)

Boston high school? (Meek) Brr . . . (Meek)

Yes, it was. Twenty years ago. (Definite)

It was (Meek)?

It was. You poor robot. (Attack)

I know it (self-attacking)

That's all. (Definite)

Here is a second example of Attack following gratification of the Meek phantom:

--We were terminating an interview—

(11:30 on the 17th then?)

Roger, over and out (laughs) (Patient punning on his name Roger)

Pretty good (hah)

Mechanical robot. That's what you are. (Attack)

Don't tell him about that (Attack).

(patient claps)

So you may go to Mars.

You won't.

You might.

You come from outer space.

That's all.

. . . (to interviewer) So you have to go somewhere now?"
Another phenomenon we have not yet called attention to is also illustrated in the previous passage: namely, that Attack is often followed by a sort of appeasement. This consists of a statement that the patient is “from outer space” or is a “smart robot”—some attention to a special quality in the patient.

The last script to be presented is a brief dramatic example of the sounds of the three phantoms and their characteristic interaction. It occurred the next interview after our first long and difficult tape-recorded session:

He doesn’t like you. He’s a Russian and he’s going to cut you up. You poor robot. (Attack) . . . You couldn’t get a job on the outside, you have voices. You’re for an experiment. (more Attack)

You’re from Atlantis.

I am (Meek)?

Yes, you are. (Definite)”

It will be difficult to summarize this material, because there is a wealth of material and, unlike the other patients, this one is not able to analyze the experience for us. In the internal conversations, the patient always seems to act meekly toward the Attacking phantom and the Definite phantom. If there were no more than internal conversations, the patient would be quite like those patients of the first group who are always obedient to their voices. He has a differentiated set of phantoms, but, like the first group of patients, he shows no choice or fight. Just Meekness. But vis-à-vis the interviewer and the world, the patient shows more than the Meek phantom. The Attacking phantom and the Definite phantom also seem to sweep over him, alternately taking control. The two previous patients
showed some capacity for identifying with their phantoms, namely Elvis Presley and the Black Animals, but nowhere to the degree which this patient shows. The two other patients seemed to show a great deal of anxiety when their phantom began to take control of them. In this patient, one phantom follows another with complete ease; the dissociation is that complete.

The less extreme cases could become observers to some extent of their hallucinatory world. Three kept diaries for me, and one typed out transcripts of what his voices said in conversing with him. However willing they were to have the interest of a medical student for a summer at the outset, they all pulled away from me by the end of the summer. They were letting me in too close, and had to distance me, to regain their distance from possible harm. They were mystified about me too, and could not tell if I was out to help or harm them. They felt safer being paranoid about me, to settle their confusion.

Change

I would like to present two cases of acute psychosis for comparison, because I believe they illustrate this remarkable matter of what it takes for the patient to regain his or her own seat of judgment, and even lose it again.

The Case of the Divine Bride. I first met this patient on our inpatient service. She was told I was the doctor coming to visit her, but she insisted that I was not the doctor, but a priest come to marry her to her uncle. She was quite psychotic indeed, living in a waking dream of this marriage.
Soon I met the uncle with the remainder of the family and I could see why she would want to marry him. He was handsome, and witty, and understanding. I was able to reduce the psychosis, along the lines indicated by Sullivan (1956), by shifting the modality of her belief, from a conviction to a wish. I said I could see why she wished she was to be married to him, so much, that she even believed it to be so in reality. Within days, she was accepting my translation, and talking about it, as if it were a wish, not true, alas, and worthy of her tears. She was grieving it.

Now I had to grasp what had driven her into this restitution, and it became abundantly clear that it was the reality of her father. He dominated the family with his self-pity which was highly articulate. His wife took a back seat to this, even though she was much the more able in social matters. His daughter, my patient, took it upon herself to protest the monologues of the father. This upset her mother, however, who had long been in favor of the status quo. She wanted my patient just to quiet down. This made my patient feel betrayed by her ally. In other words, I found myself in the middle of an imbroglio as described by Selvini-Palazzoli et al. (1989).

By backing my patient's perceptions about her father putting her mother down, and herself down, I strengthened her threatened seat of judgment. Nevertheless, I did counter her grandiosity that it was her job to set her parents straight. They were going to go on like that for their own reasons. In other words, I helped her to sort out good from bad for herself, and the limits of her power.

Her parents never thanked me for this clarification, which gave back their daughter her sanity, now well maintained for several years in a very competitive university. She got off risperidone in six months, and has not needed any since. She has
done well, if she has had crises, around being judged by roommates and faculty, as by her parents. Yet she has sorted them out, without resorting to a psychotic compensation. The parents never thanked me, because their daughter’s clarity has been perverse for them, and caused them more pain in facing their miserable marriage.

The Case of the Self-Conscious Son. I saw this young man quite like the last patient in an acute psychosis. His was less florid, and consisted of voices making a running commentary on his actions. He had become disturbed enough to drop out of school and become hospitalized. Like the last patient, he was put on risperidone which was gradually increased to 6 mg.

My first interview with him on the inpatient service was less dramatic, but I did take a good history. I found that he retreated from his family in high school into marijuana, and that he had been very disturbed here by his roommates who put him down. He had been a kind of sheep with his parents, and now his roommates.

He had felt unable to defend himself with either. His father was unanswerable. His roommates made him the butt of jokes. Gradually, he lost confidence, and one day began to hear his voice of commentary.

My tack with him was to clarify his own judgments. Gradually, he began to disagree with his roommates, and with his parents. They wanted him home in Chicago, and he wanted to stay here. I stayed out of it, and let him settle his own dilemma. He elected to stay here, and take a partial load of classes.

We always discussed the same sort of thing, which was when he felt victimized by the judgments of others. For example, he left a class exam very early, and feared he had hurt his professor’s feelings for making the test look too easy. This seemed to be a
terrible error. For example, his roommate told him he had paranoid schizophrenia like the roommate’s brother who was indeed a tragic case. This also seemed terrible to him, to be classed with this most unfortunate fellow. I got him to voice his own opinions, both in the terrible version, and in a more moderate version, and let him settle it. By the end of the semester, he was fine on 3 mg risperidone, and went back to Chicago for Christmas break.

On his own, he decided to stop taking risperidone to please his father. He began to deteriorate back in the family bosom. I got a call from his mother, asking if he could get back on risperidone, and I agreed fully, and asked if he was coming back to see me.

He came back in a fully psychotic state, shaking, accompanied by his mother. I asked him when this had begun, and he said a few days before. I asked if he had had a bad dream (Sullivan, 1956), and he had indeed. The dream was that he was trying to buy a sailboat from someone who did not want to sell it. His mother exclaimed that that must be the sailboat he shared with his father. I said that he must have feared that he was being cut out of the sailboat by his father! Now, his eyes seemed to pop, and he woke up, from this waking nightmare, and stopped shaking, and was himself again.

His mother was astonished and took him back to Chicago, and I never saw him again. He relapsed, back in the bosom of the family, back in terror of his father, and was hospitalized in Chicago.

In other words, the recovery of his seat of judgment was relative to where he was placed. With some backing, he could manage, but he could be easily overwhelmed as by his father. Cameron (1961) had a case like this one of a patient like a sheep at the mercy of the wolves. This patient took three or four years of discussions like ours, before she
could withstand the impact of her powerful family. Indeed, she could not do it until she had introjected the doctor’s own voice, as a firm counter to the witches!

More Modest Changes

Once these acute psychoses become chronic, they are very likely to settle there, circulating between near and far from the voices, and from the world. The patient cannot make up his mind, and is buffeted endlessly by the opinions of others, including those of the voices. Still, he appreciates a little understanding.

The Case of the Son of the Doctor. A colleague called me about this case, who was the son of a doctor. He faltered in his studies in college, and dropped out. He considered himself to be a terrible failure. He heard voices. He retreated into the in-the-corner lifestyle, and had no confidence to come out. Gradually, my colleague encouraged him in a modest trade, and he did it all right and became self-supporting in a neighboring town. He is marginal. My colleague was curious what I thought had made the difference? My reply was that the lad had found a value in himself after all, with the help of his excellent and modest doctor.

The Case of the Patient Guilty of Masturbation. I have seen this middle-aged man many times with one of our residents, and he always complains that he tried his studies, but he became too nervous. Then he says he has been masturbating too much. One day I said to him that he always has to go backwards, after he has gone forwards. He shook my hand, standing up, and said ever so lucidly, “I suffer from lack of a wife, and the fear of having no money.” A tear was in his eye, partly of gratitude.
The Case of the Man Terrorized by His Neighbors. I have also seen this man many times with several residents, and he always complains that his neighbors are too loud. This makes him very angry. Then he fears they will get him back. One day he had a new resident who heard this story in my presence, and the new resident asked if he might speak up to the neighbors? The patient was silenced. I said that I doubted if he wanted to risk that. To my astonishment, the patient turned to the resident, and said ever so lucidly, “Dr. Gustafson explained to me before that their anger at me is just my own projected.” He didn’t wink at me, but I was as floored as if he had.

The Case of the Psychotic Stare. I just met this man recently, who was introduced by the resident as having a problem staring at people. The resident had tried adding clonazepam to his olanzepine but the patient stared as before. Indeed, he was now staring at me. I asked him what went through his mind when he was staring. He said he imagined himself to be a soldier in a war! I replied that that was a good idea, for it kept him vigilant. He smiled, and relaxed his stare. Then I said I had to go, with such a busy schedule of five minutes per patient. I pointed to my list. He laughed and rejoined, “You think you have a hard job. I’m a janitor and have to go out into the cold in winter!” I laughed, and admitted he was right.
Appendix. A Theoretical Note.

I have written this book up until now for everyone in psychiatry. I have described twelve circular dynamics, with their presentations, their histories, and their possibilities for change. I believe that anyone in our field can grasp these twelve circles, one at a time. Each is a simple diagram, which can accrue complications.

I am now writing this theoretical note about the scaffolding which has allowed me to construct this book. I don’t believe many will be able to comprehend it. I would recommend to most readers that they stop here, and not vex themselves with this beautiful mathematics.

I have presented various of these theoretical ideas for over thirty years and only once had a colleague write back to me some understanding of what I had demonstrated. This lack of comprehension is no accident at all. Gregory Bateson (1979) explained it very clearly. The capacity for recognizing larger “patterns that connect” has almost disappeared from our educational system, which is focused very narrowly on specialization, on the one hand, and fashion, on the other hand. Scientific will rules technology, and romantic will rules the grandiose images with which it is sold to the general public (Tate, 1948). This is our Protestant system, which sprang up on the shores of Lake Geneva in Calvinism, and has taken over the entire world. I say Protestant because it is a culture with a calculus of productivity, which was built upon the calculus of good deeds, to prove one was of the Elect of God (Weber, 1904-05).