

Running Head: SYMBOLIC REALIZATION

Symbolic Realization:

A Psychosocial Rehabilitation Approach to the Treatment of Schizophrenia

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Signature Page

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Abstract

Symbolic Realization is an approach that emphasizes psychosocial rehabilitation in the treatment of schizophrenia. The purpose of this literature review is to provide an alternative to the medical model of treatment for schizophrenia. The current paper includes a review of Margarite Sechehaye's published literature, as well as reviews of modern authors that have researched the subject. Personal observations and discussions are also included in the material. The findings, in the published literature, support the effectiveness of implementing a plan emphasizing psychosocial rehabilitation as described by the technique of Symbolic Realization. The results of this research are geared towards bringing new light to a therapeutic approach to the treatment of schizophrenia. As a serious mental illness, with multiple etiologies and a record of poor treatment outcomes, the exploration and use of an old technique appears to hold promise.

CHAPTER ONE: Symbolic Realization: A Psychosocial Rehabilitation Approach to the treatment of Schizophrenia

To begin a discussion about a specific technique to treat schizophrenia such as Symbolic Realization, it is critical to understand why it is important to treat schizophrenia. For this reason it is critical to answer a very important question:

1.1 *Who Suffers from the Illness?*

According to the website for the *Merck Manual* (2003), schizophrenia affects one percent of the world's population. It is believed that in the United States approximately 2.5 million people, or one in 100, have schizophrenia and 1 in 10 young schizophrenic males commits suicide (McGuire, 2000). This significant statistic gives us an idea of the need for effective treatment, since we have been unable to treat it effectively.

One promising option for treatment is Psychosocial Rehabilitation in the form of Symbolic Realization. Therefore, the purpose of this thesis is to introduce to the reader the work of Margarite Sechehaye, and related works of other modern authors who have researched the subject and come to very promising conclusions.

In order to understand the issues and relevance of Symbolic Realization I have limited my work to very specific information that I consider relevant and interesting to deliver to the reader. Hence, I will not present a comprehensive literature review of the history of etiology and treatment of schizophrenia. Instead, I will review only some modern etiologies in continuous research, diagnostic criteria, and other possible treatments for schizophrenia.

1.2 *Overview of Some Modern Etiologies of the Illness*

To understand schizophrenia we need to review some theories that attempt to

explain its genesis. Schizophrenia has historically been considered an enigmatic cluster of disorders (Crow, 2001). Crow, also wrote that Bleuler believed it to be many illnesses together where delusions, hallucinations, and disturbances of thought are present. Since the etiology of the illness is uncertain, I am presenting the reader with some modern etiologies (which are currently being researched) that are very recent. The theories to be presented are as follows: The exposure of the fetus to a virus during gestation and two novel theories on genetic mutation.

Some novel scientific theories have linked schizophrenia to the exposure of the fetus to a virus during gestation (Munn, 1998) and genetic mutations (Glausiusz, 2002; "French Study," 2002). The theory of exposure to a virus during gestation is termed microglia dysfunction and was postulated by psychiatrist Nathan Munn (1998). Microglia are a specific type of cell in the nervous system. Microglia cells conglomerate in massive quantities in places of disease in the nervous system to take away the scattered remains of damaged or unused nerve cells. During neurodevelopment, microglia cells act on the nervous system by taking away the nerve cells that will not be needed in the developing human being. If at any point during neurodevelopment a virus affects the microglia cells, the cell's immune system can be altered, possibly causing an enlargement of the ventricles of the brain. The alteration of the immune system of the cell may increase the probability of the onset of schizophrenia in adulthood. Munn (1998) hypothesized this correlation based on studies that have shown the relationship between microglia cells and different ailments, such as immune diseases. A high incidence of individuals with schizophrenia has been observed to have conditions related to dysfunction in the microglia cells (Munn, 1998).

Another explanation for schizophrenia is genetic mutation, which is one of the top priorities of genetic research in schizophrenia. As reported by Glausiusz in a major circulating newspaper in the Dominican Republic, Dolores Malaspina, a Dominican psychiatrist adjunct to Columbia University in New York, found that there is a correlation between schizophrenia and sperm mutation (2002). This correlational research, conducted in Jerusalem, was based on the review of clinical records of more than 87,000 clients. All patients were considered "borderline schizophrenics" at risk of developing schizophrenia. Of the 87,000 clients, 658 developed the illness. Of those that developed schizophrenia, one in 47, were born from fathers who were between 50 and 54 years old. These findings suggest that having an older father may increase the risk of genetic disorders, including schizophrenia, in the offspring (Glausiusz, 2002).

Malaspina (Glausiusz, 2002) also found that the symptoms of one-fourth of the individuals with schizophrenia originated from automatic mutations of the father's sperm. These sperm mutations occurred more frequently in men over 50 years old. Malaspina concluded that the older the father, the higher the offspring's risk of developing schizophrenia (Glausiusz, 2002). This research suggests that to reduce the incidence of individuals developing schizophrenia men should have their children before they reach the age of 50. Meanwhile, genetic research continues to try to isolate the specific gene that causes sperm mutation in men who have their offspring after they reach the age of 50.

Another recent study in gene mutation was conducted in France. A team of French scientists conducted a study in gene mutation and found that there is a genetic mutation in the 22nd chromosome that appears to be related to schizophrenia ("French

Study,” 2002). The French scientists observed that many of their clients with schizophrenia displayed a genetic anomaly in the 22nd chromosome. This anomaly causes the overproduction of an amino acid called prolina, an overproduction that could be controlled by human means. The article does not specify the means to control the overproduction of prolina, yet it seems that the amino acid prolina could be isolated. These French scientists observed the 22nd chromosome of many individuals with schizophrenia through a new laboratory procedure called genetic amplification. The utilization of genetic amplification helped determine a correlation between schizophrenia and the overproduction of prolina. This research is ongoing and, so far, only the positive correlation between schizophrenia and prolina has been established (“French Study,” 2002).

1.3 *Diagnostic Criteria*

Evolutionary psychology agrees that schizophrenia is a disease, which tells us about the natural selection of communication. Evolution gives us an idea of how nature used genetics to adapt the communicational skills of human beings from thought processes to speech processes (Crow, 2001). According to Crow this adaptation is important to our understanding of schizophrenia because it seems that individuals with schizophrenia experience an interruption in the transition between the thinking of and the expression of a thought. As a result, the individual is unable to communicate clearly with others, leading to the distorted communication characteristic of the illness.

The Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV) provides a more developed and detailed symptom list for the diagnosis of schizophrenia (1994). As long as the symptoms are not related to other conditions, the diagnostic

criteria are as follows (see also appendix):

- (1) Delusions
 - (2) Hallucinations
 - (3) Disorganized speech (frequent derailment or incoherence)
 - (4) Grossly disorganized or catatonic behavior.
 - (5) Negative symptoms, i.e., affective flattening, alogia, or avolition
- (p.285).

Schizophrenia has ubiquitous symptoms according to Stromgren (1987). Two types of symptoms in this “split mind” disease were noted: basic and accessory symptoms. The basic symptoms are organically originated and permanent, as in disorganized thought. Disorganized thought processes are believed to be caused by irregular brain function. On the other hand, accessory symptoms, such as delusions and hallucinations, are a consequence of the basic symptoms. Stromgren wrote that the accessory symptoms fluctuated from one episode to another: the symptoms might disappear, increase, or decrease (1987). The classification of the symptoms into basic and accessory caused some controversy because it presupposed the illness to be solely caused by biological conditions. As a result, Stronger (1987) believed that because of the symptom classification we still have trouble delineating schizophrenia as a specific illness caused by organic and environmental conditions.

1.4 *Possible Treatments for Schizophrenia other than Symbolic Realization*

Based on the DSM IV diagnostic criteria, there are diverse treatments for schizophrenia. The most common treatments are psychotropic medications and psychotherapy.

Psychotropic drugs are, more often than not, the preferred treatment because they produce faster results in the form of diminishing delusions and hallucinations. Even though psychotropic medications reduce delusions and hallucinations, they do not cure schizophrenia nor do they eliminate all the symptoms of schizophrenia. Many medications have been used in the treatment of schizophrenia, yet for the purpose of this thesis I will use Risperidone (an anti-psychotic medication) as an example (Steele, 2001). According to the web page of the National Library of Medicine (NLM) (2002), Risperdal (Risperidone's brand name) is one of the most prescribed psychotropic medications in the USA, because it seems to effectively treat hallucinations, delusions, and hostility without the feared side effects of tremors or catatonic movements. Risperdal seems to cause less discomfort than other drugs like Haldol, which tends to slow down and stiffen the motor movement of most users. The down side of Risperdal (NLM, 2002), as well as other psychoactive drugs, is that it does not treat the social and psychological deficits associated with schizophrenia, such as adapting to routine social interactions and performing up to standard in the work force.

Psychotherapeutic treatment emphasizes the exploration and implementation of psychological strategies to treat schizophrenia. Among the most practical psychotherapeutic treatments are Family Therapy, Inter-Personal Therapy (ITP), and Milieu Therapy (Seligman and Rosenhan, 1997). Family Therapy is very efficient in targeting the problems of schizophrenia in a family system, where the individual with schizophrenia and the family interact. Both the family and the mentally ill person learn how to cope with schizophrenia and gain skills to deal with different decisions and arising problems. These learning experiences are combined with interactions designed to equip

the individual with better social skills (Seligman and Rosenhan, 1997).

According to Seligman and Rosenhan (1997) Inter-Personal Therapy is “a set of structured intervention programs that are derived from cognitive and behavioral principles and that attempt to remedy the cognitive and behavioral dysfunctions that are characteristic of schizophrenia” (p. 303). This type of psychotherapy seems to improve the cognition and social interactions of individuals with schizophrenia.

Milieu Therapy emphasizes training on work skills, social contact, and on how to enjoy recreational time. Milieu therapy encompasses most of the areas of life’s routine. Most hospitals include this type of therapy as a means to help their clients deal with everyday life outside a mental institution (Seligman and Rosenhan, 1997).

Another apparently successful approach to the treatment of schizophrenia is a modified version of the psychoanalytic approach. This modified type of psychoanalysis is Symbolic Realization, created by M. Secheyay in the late 1930’s. Secheyay created a systematic approach in which the client and the therapist establish rapport and interact in mutual agreement to help alleviate the ill person and work together to recover from the schizophrenia (Secheyay, 1951). This systematic approach, as the reader will see, is a form of psychosocial rehabilitation technique in which the therapist establishes rapport with the client, and guides the client through the process of rehabilitation. It is the intent of this thesis to explore in depth the work of M. Secheyay in Symbolic Realization and its value in the treatment of schizophrenia.

CHAPTER TWO: Symbolic Realization

Although the biographical information available for the life and work of Margerite Sechehaye is limited, we do know that she developed her professional career in France and Switzerland. It is also known that she was a successful psychiatrist and a psychoanalyst, who applied different therapeutic approaches in working with her clients (Sechehaye, 1949). According to some of Sechehaye's writings, she combined psychotropic medication with psychotherapy (1951). The focus, however, was to reduce the use of the medication until remittance, and to help the client live a full life without medication or dependence on his or her doctor. Her philosophy regarding prescribed psychotropic medications was moderate; she believed that medications were to reduce discomfort, not to incapacitate the clients (Sechehaye, 1951).

Because of Sechehaye's integrated approach to therapy, an attending psychiatrist referred a young lady named Renee to her in the 1930's. Renee was approximately 18-19 years old and had been diagnosed with delirious-hallucinatory schizophrenia (general schizophrenia) by several psychiatrists. These psychiatrists were not successful in finding relief for her symptoms, other than psychotropic medications and shock therapy (Sechehaye and Renee, 1951). Sechehaye decided to reevaluate the client, and found that the client showed neurotic symptoms and delirious-hallucinatory schizophrenia. Even though the client, Renee, was ill, she desired to be healthy. Because of the neurotic component of Renee's illness, Sechehaye thought that the client would benefit from psychoanalysis. She observed that psychoanalysis decreased the neurotic symptoms, such as the anxiety of not having someone to rely on and trust.

Despite some progress, psychoanalysis did not relieve Renee of her hallucinations

and delusions. There was some improvement, however, and Renee was able to finish high school. Once Renee finished high school, Sechehaye observed that Renee had fallen into a regressed state. Sechehaye decided to reevaluate her therapeutic procedures and determined that psychoanalysis did not satisfy the needs of her client. In the process of reevaluating the treatment Sechehaye discovered that she was not communicating effectively with Renee. Sechehaye was focusing on the neurotic symptoms and not on the core symptoms of schizophrenia. When she shifted the focus of her treatment from neurotic to schizophrenic symptoms, Sechehaye observed that Renee's thoughts, when put into words, seemed to represent a symbolic association. This discovery led Sechehaye to attempt to understand her client's world using symbols (Sechehaye, 1951).

Based on her discovery of the importance of symbolic communication, Sechehaye established a treatment plan that would help translate reality into the symbolic language that Renee understood. Using symbolic language, a communication channel opened between Sechehaye and Renee, which created an opportunity to teach Renee the parallels between her own world and what was real. The purpose of the new treatment was to make available a bridge of communication between the therapist and the client, and to recall the client from her symbolic world into reality. This approach allowed the client's abilities to be preserved, which meant that the individual's personality and potential were safeguarded. Once the communication was opened through a symbolic interaction, a prognosis and diagnosis were more easily defined. Sechehaye observed that even if the client is in a symbolic world and the therapist is not, the therapist can communicate with the client because the therapist is equipped with an understanding of the client's symbolic world. Sechehaye named her approach Symbolic Realization Therapy (Sechehaye, 1951).

Sechehaye created the technique of Symbolic Realization by modifying psychoanalytic techniques. Her observations and research about the course of the illness led her to reason that psychoanalysis provided an effective treatment for the unstable state and contradictions that are typical within schizophrenia.

Symbolic Realization Therapy is sequential and structural, which means that the therapist and the client work together through a methodically developed plan until recovery or remittance is achieved. The length of therapeutic intervention depends on the severity of the case. Symbolic Realization can be used with individuals who develop or show signs of schizophrenia at any point in their life. These individuals did not develop the illness due to a medical condition. According to Sechehaye (1951), the symbols used with any given client need to relate to the client's reality. The symbols need to be a parallel between the client's reality and his or her circumstances.

For example, in Renee's case, one of the symbols used was a real white rabbit. This white rabbit represented a white rabbit that Renee had as a 14-month old girl. For an unexplained reason, Renee's father killed the rabbit in front of her. As a result, Renee perceived the event as if she did not have the right to live, because she was attached to the rabbit and the rabbit ceased to exist. When Sechehaye connected the death of the rabbit with the feelings of helplessness in Renee, she realized the symbolism of the rabbit for Renee. Sechehaye understood that Renee interpreted the event to mean that she was not permitted to live or enjoy life. As a result of this insight into Renee's illness, Sechehaye gave Renee a white rabbit similar to the one she had as a child. This action helped Renee to gain confidence in life itself, accepting that she could live. Thus, Renee also regained confidence in herself as well as in her analyst.

As a result of her work with Renee, Sechehaye developed the concepts of Symbolic Realization. In her 1951 work, Sechehaye presented ten core factors, which describe the reeducation process Symbolic Realization. These factors are as follows:

- The development of the client's confidence: This aspect depends upon the severity of the case and the need of the client. Renee, for example, needed to learn to trust; therefore, the therapist wanted to reassure Renee with words and actions that she would honor the commitments she made to Renee.
- The reassurance of the client: This refers to the reinforcement in the client of a sense that the treatment is working, and motivating the client to continue improving until remittance from the illness is realized.
- Inference of the client's needs and interests: This factor refers to learning the basic needs of the client, and noticing where the client is fixating (associating an event with a specific emotion). When fixation is encountered, it is necessary to retrieve the client from it, through the structural symbolism according to the circumstance. For instance, In Renee's case, we find that she was neglected as a child in the daily provision of her meals. Therefore, her therapist decided to provide Renee with appropriate meals at a consistent time (since the client was in the hospital, it was easy to reinforce the plan).
- Provide continuous satisfaction of needs and permitting the expression of new needs: The client should be provided with whatever is desired, within reason. Nevertheless, it is necessary to establish and maintain proper boundaries. In Renee's case, Sechehaye created a plan for Renee in which she provided Renee with basic items such as food. These provisions were supplied as long as Renee asked for them.

Sechehaye also planned activities, such as outside walks (around the hospital, or in selected locations such as gardens), knowing beforehand that Renee desired the activity.

- Guide the client through new desires: According to the developmental stage currently experienced by the client. This concept entails guiding the client through the different developmental stages, taking care not to skip any. This process helps to prevent remission. An example in Renee's case was the interaction she had with her therapist. This relationship helped Renee to desire the responsibilities and benefits of the following stage. Sechehaye would ask Renee if she would like to visit someone, and then she would let Renee make her own decision.
- The development of attention: The goal of this step is to keep the client focused on specific objects, so the objects can be associated with the client's reality. It is important to ensure that the objects and events will be associated with positive and healthy emotions. In Renee's case, Sechehaye would encourage Renee to observe the flowers during their routine walks. Later, Renee would associate flowers and nature with an enjoyable experience.
- Teach the client time management: Sechehaye emphasized the importance of a daily routine to establish habits in the client. Renee, for example, had a specific bath time.
- Self-sustaining activities: Through this concept, the client is offered activities that will support independence and self care. The activities are offered to the client until the activity is desired. For example, the therapist repeatedly offered Renee a book to read until she expressed a desire to read the book.
- To exclude inadequate methods: Sechehaye proposed that therapists should learn to

reinforce the therapeutic plan without punishing the client when the plan is not followed. The therapist needs to explain to the client why the treatment is to be followed and the consequences of not following it. This explanation needs to be provided at the level of understanding of the client.

- To have an able assistant: The therapist needs someone with a strong psychological training and the intuition to assist the client in day-to-day tasks, who is able to apply the therapist's instructions precisely.

Sechehaye argued that the psychological factors that influenced Renee's recovery could be a key factor in the recovery of other individuals with schizophrenia (Sechehaye, 1951). The factors she identified as critical are as follows:

- The Symbolic Realization Method: Symbolic Realization, as stated previously, involves communication through symbols, in which the therapist comprehends the client's thoughts and inner world through the symbols that they represent. These symbols are a tool for the therapist to understand the reason why the client has distorted cognitions and help the client to re-channel his or her cognitions adequately to his or her reality. In Renee's case, this method opened a door so the therapist could enter into and understand Renee's world. Understanding Renee's world helped the therapist find the path for Renee's recovery.
- Reeducation: Secondary to the Symbolic Realization method, reeducation is a key in the reintegration of the client into society. During the reeducation process, it is important to work through the training plan at the client's pace. This precaution is to prevent relapse. Relapse is a risk whenever clients are asked to take on new responsibilities or to perform beyond their attained stage. For example, if Renee was

asked to read a book with which she had not identified, then she could be submerged into an autistic state because she would not comprehend why she should read the book.

- **Emotional Influence:** Transference plays a big role in the improvement of an individual with schizophrenia. The client needs someone in whom he or she has confidence and trust. Along with trust and reliance comes empathy. Empathy is the capability to genuinely feel someone's needs and emotions. The sympathy of the therapist will reinforce the confidence of the client in the therapist. In Renee's case, a positive transference occurred. Sechehaye was able to become the mother that Renee was lacking at that point in her life, and as Renee remitted from schizophrenia she comprehended that Sechehaye was not her mother but someone she could trust and upon whom she could rely.
- **Favorable Conditions:** This concept includes not only the therapist as the person who cares for the health of the client, but also capable assistants. It is extremely important to have assistants trained in psychology or psychiatry who can carry out the instructions of the therapist with authenticity and professionalism.

According to Sechehaye (1951), preparing a symbolic communication and establishing a plan to reeducate the client has the potential to retrieve the client from the stages of fixation. This therapeutic plan can strengthen the ego structure of the client (in psychoanalysis, the ego is the part of the self that follows the principles of reality, interpreting the outside world to the self), and from this point, the client can keep growing developmentally. It is a way of re-building the ego, so it bridges the id and the superego in a healthy manner.

Sechehaye (1951) pointed out that an individual with schizophrenia is capable of communicating, and relating with others through a symbolic language. She demonstrated the parallelism between the thought process of an individual with schizophrenia and that of a child. Like a child, an individual with schizophrenia has not developed the ego; therefore maturity is an issue that needs to be addressed. Hence, the world is more meaningful through symbols and non-verbal communication. According to Sechehaye (1949) and Besson (1995), implementing Symbolic Realization as a therapeutic treatment considerably improves the client's understanding of the real world and its dynamics. This improvement helps the individual to cope with his or her environment and what it represents, leading to a gradual remittance from the illness.

Starting with Renee, Sechehaye (1951) realized that with medication alone, or in combination with traditional psychotherapy, the prognosis of the client would not be favorable. However, when she implemented the Symbolic Realization psychotherapy, the prognosis changed and the client improved considerably. Renee not only stopped taking the medication incrementally so her body's homeostasis would not be affected, she also experienced remission from the illness through continued Symbolic Realization psychotherapy. Renee was in treatment for approximately ten years, from 1932 to 1942. Seven years later, with the support and guidance of her therapist and the community, Renee was still free from schizophrenia and keeping in touch with her therapist. Remarkably, Renee experienced complete remission from the illness, graduated from the university, and published two books. 2.1

Some of Sechehaye's Published Work in Symbolic Realization

In the aftermath of Renee's remittance from schizophrenia, Sechehaye published

most aspects of her work on the technique of Symbolic Realization and her discoveries regarding treatment of individuals with schizophrenia. Among the most important published material we have in order of precedence: "The Diverse Aspects of the Schizophrenic Me" (1965), "Gratification Techniques in Psychoanalysis" (1960), "The Transference in Symbolic Realization" (1956), and *Psychological Diagnostics* (1949).

An important work, of Sechehaye (1965), in understanding the shattered schizophrenic individual is "Les Divers Aspects Du Moi Schizophrenic" ("The Diverse Aspects of the Schizophrenic Me"). In this article, Sechehaye (1965) explained the processes of a psychotic mind, and how the therapist can identify, in an individual with schizophrenia, the "me" (self) from the "schizophrenic me" (schizophrenic self). In this article, she emphasized the importance of understanding the developmental stage of the id, ego, and superego in the individual. Today professional mental health practitioners utilize the same approach with neo-Freudian ego psychology. Sechehaye discovered through her work that to understand schizophrenic personality development, we must first understand how, in Freudian terms, the id, ego, and superego interrelates. In other words, we need to have a clear understanding of how the instincts, irrational acts, pleasure-demanding, and impulsive side of an individual are moderated and balanced between the over-rational, legalistic, full of "shoulds" and "oughts" side of that individual. The sum of instincts, moderations, and "shoulds" of the individual with schizophrenia needs to be observed and analyzed in contraposition to the individual's environment and own reality. Based on this Freudian description of personality, it can be explained that since the ego is not able to mediate between the id or the super ego, the result is a deep anguish at the core of the psychosis. Therefore, the psychosis develops as a defense mechanism,

helping the affected person cope with the exterior world.

The "schizophrenic me" is a self that has regressed to a primitive stage. In this regressed stage, the affected person is unable to experience every one of the developmental stages appropriate to the client's chronological age. This aspect is the premise of the attachment theory. There are numerous defense mechanisms functioning in the schizophrenic individual, which leads us to surmise that there exists a diversity of types of the "schizophrenic me." It is interesting to observe that due to different circumstances, we are able to see the "schizophrenic me" in parts. According to Sechehaye (1965), the parts of the schizophrenic me can be seen as the pieces of a puzzle. It is the therapist's task to visualize the pieces and put them together.

Research in ego psychology has revealed three aspects of the schizophrenic personality. These aspects are as follows: The "adult me," the "regressed me," and the "psychotic me." Sechehaye (1965) explained that there is a dissociation among the three aspects of the schizophrenic personality, yet they feed each other, and combined they explain the psychotic personality of the schizophrenic individual.

The "adult me" is explained as a developed and neuro-physiological aspect of the person that has been neutralized; therefore, it is not able to deal with the psychosis. This aspect is lucid and capable of recognizing that something is going wrong within the individual. It performs the function of the ego and is the mediator between every episode of the psychosis. According to this ego theory, the "adult me" is constantly bombarded with the crisis and instability that the individual with schizophrenia suffers. The "adult me" helps the "schizophrenic me" develop a mechanism of defense, such as regression, to help protect it from the anguish of the illness, its delusions, and hallucinations. This

regression is progressive depending on the escalation of the psychosis, and its purpose is to protect the affected person against the guilt of the schizophrenia. It is important to keep in mind that even though the "adult me" is going to be overcome by the "psychotic me," it will still have the ability to perceive, sometimes judge and even choose in lucid times. During lucid periods the therapist should connect and establish rapport with the client. The therapist should be aware that the client might express him- or herself in a symbolic language. This symbolic language could be manifested in the client as talking in a circular fashion instead of a direct fashion. For example, the client could state that someone else has his or her clothes so tight that that the person cannot breathe. The statement actually reflects the state of the client's own inner self, in this case, a sense of feeling stuck.

The "regressed me" permits the survival of the individual with schizophrenia. It is a state of regression that enables the client to deal with the disintegration of one's functions. This aspect of the "schizophrenic me" contains positive and negative characteristics. One positive characteristic is the fact that the schizophrenic individual is able to deal with and interact with the exterior world. Interacting with the exterior world requires a great deal of energy from the client, and all this energy is focused on finding a way to communicate with one's environment. This manner of communication constitutes a syncretism of symbols and needs. Next comes the step in which the "adult me" learns to communicate the symbols. It also includes the desire of having one's internal needs satisfied. This communication is similar to the attachment theory (this theory explains the need for human-beings to bond with others in close and meaningful relationships), wherein the needs of each stage of development need to be satisfied.

The “psychotic me,” also called the “victorious and defeated me,” is considered “victorious” because it helped the client to hide from the reality of suffering, since one’s energies are exhausted by concentrating in dealing with the illness itself. It is “defeated” because of the phases that the client experiences, namely, the delusions and hallucinations that come with the illness. Every phase that the client goes through is a way to protect oneself from the disintegration that the illness causes.

In conclusion, Sechehaye (1965) explained that the work of the therapist consists of helping the client become integrated, and understanding the illness and the procedure to treat it effectively. It is in the best interest of the client, and should be the job of the therapist, to help the client deal with the ups and downs produced by schizophrenia.

Sechehaye (1960), in “Techniques de Gratifications en Psychotherapie Analytique” (“Gratification Techniques in Psychoanalysis”), also explored the techniques of rewards in psychotherapy with individuals with schizophrenia, specifically in Symbolic Realization. The gratification is based on offering the client more rapport and interaction (involvement) than what classical psychoanalysis allows. With these techniques it is important to take into consideration that there are guidelines for what is indicated and contraindicated. These guidelines are addressed specifically because the application of this technique without discernment could deprive the schizophrenic individual of the desired healing process that he or she needs in order to be alleviated from the illness. At the same time, the individual could be deprived of a healthy transference-attachment needed to overcome the feelings of isolation that evolve within the illness itself.

Sechehaye (1960) presented some examples of situations or diagnostics indicating when to use gratification (rewards):

- Pseudo-schizophrenics. These are cases of schizoid type disorders that are classified as neuroses. If the therapist confuses schizoid cases with schizophrenia, he or she may proceed with a classical psychoanalytic therapy, not taking into consideration which specific techniques will benefit the client. If an individual is treated for an incorrect diagnosis, then the therapy or the technique does not help the client. According to Sechehaye, these clients are in danger of going through a process of transference that will not benefit them, because they are not capable of dealing with the frustration of detachment from the established transference. Identifying a client in this situation will become a vicious cycle in which the client will learn how to manipulate his or her analyst, and the analyst could become a toy to the client. This game between analyst and client could become an endless process. Therefore, it is recommended that the therapist be very cautious in applying a specific technique, and to avoid the use of a technique of gratification in cases of pseudo-schizophrenia.
- "Limited cases." These cases include situations in which the individual is between a neurosis and a psychosis; for example, a major depression. In these cases a gratification is not appropriate, because these clients are so entangled in their frustration that they may seek to act on it in a masochistic fashion. Schizophrenic individuals maintain themselves within their frustration as a method of justifying their anger towards the cause of their depression, and this frustration is necessary so they can get the anger out. In gratifying the client's, the only thing the therapist succeeds in doing is to block their anger and increase their guilt because the clients then cannot express their anger. According to Sechehaye (1960), what these clients need most from their therapists is patience, empathy, and continuing reassurance that they will

not be rejected.

- Schizophrenics. This population is very special regarding the techniques used.

Because they exist within a regressed state, and even though their behavior might be infantile, it is in their best interest to consider them as their chronological age. For example, an inexperienced therapist took as a client a very aggressive schizophrenic individual. During the sessions (Secheyay, 1960), the individual would act very aggressively, and the therapist, in his inexperience, started offering candy, cigarettes, chocolate, and fruits, to try to stop the aggressive behavior. In response to this attitude, the client felt disappointed in his therapist, and stopped going to therapy. Eventually, the client started going to another therapist and when asked why he did not continue with his previous therapy sessions, he replied that he felt that his previous therapist did not accept him for how and who he was, but instead attempted to bribe him by offering him candy, chocolate, etc.

The above example explains the importance of learning to accept clients as they are and for whom they are. It also demonstrates the inappropriate response of bribing clients in exchange for appropriate behavior. If therapists do not take into consideration what this case demonstrated, it will imply to clients that they are not important enough for therapists to understand them and that they simply want to get rid of them. In this article, Secheyay (1960) emphasized the importance of accepting the schizophrenic individual through all the stages of the illness, whether aggressive or not, without exhibiting fear of him or her. Thus, gratification is important, only if provided carefully and in the dose needed by the client at the appropriate stage.

- Psychopathic personalities. These cases will not benefit from gratification, because

the affected persons live in a constant state of instability and are very controlling. If a psychopath is gratified by his or her therapist, it would be interpreted as a seduction. The client will not interpret that the therapist understands the client, but rather that the client is being seduced, and the client will feel that accepting the seduction gives him or her the right to be controlling and possessive with the therapist.

In conclusion, when practicing therapy, it is important to take into consideration the knowledge gained by study, experience, and practice, along with wisdom and intuition. On the other hand, a therapist should always understand the expression of the needs of one's clients, and work with them in fulfilling those needs.

In "The Transference in Symbolic Realization" (1956), Sechehaye explained how transference could occur with an individual with schizophrenia through the technique of Symbolic Realization. This transference could occur in multiple steps, since an individual with schizophrenia has a hard time maintaining contact with reality and real relationships. Due to the fact that relationships are disturbed, there is a loss of existence, a loss of identity, and a loss of his or her situation in the world. The therapist needs to introduce and prepare the client for a transference, in a way that best suits the individual client.

The steps to accomplish transference in schizophrenia, through Symbolic Realization, are as follows:

- Pre-transference. The first step is to establish rapport and cultivate a trusting relation with the client. Establishing an empathetic relationship with the client will result in welcoming the therapist to the client's obscure world. The most important thing to remember is to make contact with the client at the client's level of regression in order

for the therapist to be accepted by the client. For example, a six-years- old girl with schizophrenia (who did not want anyone to touch or talk to her) considered her feet to be the only real part of her body. Thus, the therapist decided to establish rapport with her client's feet. The therapist talked to her client's feet like talking to a real entity. The client did not pull back from the therapist, and as the therapist talked to the feet, the client answered the therapist and allowed the therapist to have a relationship with her. Eventually, the therapist was able to have a direct communication with the client to the point that the client desired the relation. In this pursuit of establishing a relationship with the client, the therapist will encounter some opposition and resistance. Yet, the therapist should continue trying to establish rapport with his or her client until the client realizes that the therapist is genuine and won't give up on him or her.

- Transference. In the words of Sechehaye:

Once attained, we witness a fundamental change in the client's behavior. Feeling him/her self understood, protected, loved, the client begins to formulate his/her primary needs, no longer in delusional-psychotic expressions, but in a purposeful way, that is to say he/she directs his/her needs towards the psychotherapist from whom he/she expects satisfaction. (1956, p. 272)

A transference with a schizophrenic individual is not intended to relive past experiences, but to connect with someone that becomes a loving parent figure and together work through the process (this is similar to Rogers' "unconditional positive

regard," meaning genuinely accepting and loving one's clients for who they are).

During the phase of transference, a displacement, a negative transference, or a counter transference could occur. Displacement is similar to attachment theory in that the client undergoes, with his or her therapist, a process that applies his or her learned skills and experience to the different stages that he or she goes through until reaching his or her actual chronological developmental stage. This procedure permits the individual to become less regressed and attain an adult behavior, thereby improving his or her experiences.

A negative transference occurs when the client regresses in the therapeutic process and the therapist has not been able to understand the regressed state of his or her client. In such cases, Secheyay (1956) recommended that the therapist stop and rethink the treatment plan, and restart from the point at which the client improved.

A counter transference is extremely important to avoid and keep under control. According to Secheyay (1956), a therapist should understand him- or herself and own his or her needs before starting the therapy process with any client. If the therapist does not understand his or her own needs, it could seriously affect his or her relationship with the client. The client's therapeutic process could be delayed, even jeopardized. The client's therapy could be terminated before the client is ready because the therapist experiences burnout with the client. In essence, the therapeutic approach to individuals with schizophrenia constitutes a lesson in self-sacrifice and self-control.

When transference is established, three main effects are manifested. These effects are as follows:

- The total dependence of the client on the therapist. During this phase, the client feels

secure and self-confident because the therapist has helped the client to overcome his or her fears and is being accompanied by the therapist through the course of the illness.

- The development of the ego. After feeling secure and gaining some confidence, the schizophrenic individual begins to regain some hope and identifying him- or herself with the world. Thus, the client realizes that he or she has not lost his or her ego. Regaining his or her ego constitutes a big improvement in the therapeutic process and the parental-tender care of the therapist reassures the client of his or her identity and position in the existent world.
- The reconstruction of the external world. As the client gains his or her position in the external world, the client gains confidence that his or her needs will be met in this existent world. The schizophrenic individual begins a process of relearning how the world functions and his or her role within it. It is a time of learning autonomy and how to exercise judgment within the client's limitations as it corresponds with his or her individuality. In this growing process the client achieves a new level of accomplishment and learns to be in tune with reality.

In the book *Diagnostics Psychologiques (Psychological Diagnostics)*, Sechehaye (1949) presented many cases in which the effects of transference are clearly explained. She also explained that is important to conduct therapy in accordance to the client's needs. This book is a series of case studies, in which Sechehaye presented the therapeutic plan that she followed according to the situation. In dealing with a client who had schizophrenia, she applied Symbolic Realization in the therapeutic plan. Following this

method resulted in a significant improvement in her clients, who successfully completed their therapy. In writing this book, Secheyay presented the idea that Renee's case was not an isolated triumph, but that Symbolic Realization can be applied in similar cases, thereby improving the prognosis of many other clients in need.

Secheyay (1951) relayed how psychoanalysis, in the form of Symbolic Realization, could be useful in the therapeutic treatment of mental illnesses such as schizophrenia. She also demonstrated the effectiveness of Symbolic Realization in cases in which the client did not know nor understand how to verbalize thoughts or desires, so the communication would not be delivered in pieces.

2.2 *Recent Work in Symbolic Realization*

In 1947 Dr. Charles Odier helped to validate the quality of Secheyay's work by presenting her book, *Symbolic Realization, A New Method of Psychotherapy Applied to a Case of Schizophrenia* (1951). Approximately fifty years later, Jean Nadal (the president of the French Psychoanalytic Society) presented the work of Jean Besson (1995) in the web page *Schizoweb* and the book *Traitement Psychotherapique D'Un Jeune Schizophrene (Psychotherapeutic Treatment of a Schizophrenic Girl)*. Besson is a French clinical psychologist who graduated from the University of Lyon. Besson illustrated a case similar to Renee's (Secheyay's client). The case is about Laura, a young Sicilian lady affected by a delirious-hallucinatory schizophrenia. Just as in Renee's case, Laura went through treatment using the Symbolic Realization method (followed exactly as Secheyay's work with Renee) for approximately five years. Just as in Renee's case, the outcome of the therapeutic strategy was recovery and remittance from the illness. Besson explained that the purpose of replicating Secheyay's work was to

determine the authenticity and efficacy of the method, even though times have changed. To his satisfaction Laura's outcome was alleviation and remittance from the illness, just as in Renee's case (Besson, 1995). Since this thesis is based mainly on Secheyay's work, and being Besson's work and exact replica of her work, I have abstained from explaining Besson's work in detail.

CHAPTER THREE: Discussion and Suggestions

After reviewing the provided information about Symbolic Realization, we can see the extreme importance of addressing and explaining an alternative to treating schizophrenia. It is crucial to keep in mind that approximately 2.5 million Americans are diagnosed with schizophrenia (an estimated 1/100 people), and that most traditional treatments have not been able to help the ill person find relief or remittance from schizophrenia. For this reason we should be open to different types of treatments that could be promising in the recovery of individuals with schizophrenia.

For many years now, different treatment theories have been brought forth for use with schizophrenic clients, yet the vast majority of them have not been effective and most have a high relapse rate. Among these high relapse treatments, we have psychoactive drugs and traditional psychotherapy (as presented in chapter 1, 1.4). Now, in the article written by McGuire (2000), we can see that an increasing number of psychologists are recognizing the effectiveness of psychotherapeutic treatments with a Psychosocial Rehabilitation approach. Psychosocial Rehabilitation has returned onto the scene due to the advocacy and need of the consumers (Individuals with schizophrenia) to achieve a stable and dignified way of life. Psychosocial Rehabilitation is defined as recovery in all but one of the social and work behaviors, no need for medicines, no symptoms, nor compensation areas of the individual with schizophrenia's life.

Even though, through the years, the psychosocial approach has been viewed with skepticism, now it is celebrated and accepted by more mental health professionals. In part this is due to the high rates of recovery as seen in longitudinal studies of schizophrenia (the Harding's research as reported in McGuire, 2000). The Harding's

research is one of the well-documented longitudinal studies to compare (32 years later) 262 patients from a Vermont model study to 262 patients from the Augusta State Hospital in Maine; both groups were diagnosed with chronic schizophrenia. In 1980, Harding and her colleagues matched both groups in age, diagnostic criteria, gender, and the length of hospitalization. The main areas of health, census data, and all the protocols were also matched. To their amazement the only area that was not a match was that patients from Maine did not receive any type of Psychosocial Rehabilitation and the patients from Vermont did. The Maine patients showed a recovery of 48%, but the patients from Vermont recovered in 62-68% of the cases, thus showing fewer symptoms, better community adjustment, and that most of them were working. What caused this difference? According to Harding (as reported in McGuire, 2000), they found that both groups were treated with different approaches. The Maine group was treated with medications, stabilized, and maintained, yet the Vermont group was based on rapport with the patient, teaching them self sufficiency, rehabilitation, and helping them integrate into the community; they were treated with a Psychosocial Rehabilitation approach.

After this study was published, many questions have arisen just as when Sechehaye developed Symbolic Realization and published her different case studies. I ask the reader to think critically about these questions as I do. What has been the critical turning point for the individual with schizophrenia? According to Sechehaye's and Harding's (as reported in McGuire, 2000) published material, the turning point for the individual with schizophrenia started when the therapist established rapport with his or her client and was able to be reintroduced to society and different occupational activities where he or she was remunerated for his or her work and self-sufficiency. In contrast,

individuals with schizophrenia that were treated with psychoactive medications end up being tranquilized without all their cognitive capacities. Even though the management of the client is easier, psychoactive medications may only mask the illness. Personal observations done by the writer, in a psychiatry unit (at the hospital) and at a certified psychiatrist's office of six clients with schizophrenia, match the data presented on the literature and in the article written by McGuire (2000).

Another question is how plastic is the brain to adapt to a psychosocial type of approach? These studies, as well as many others done in Europe and Asia have shown that the capability of adaptation of the brain to its environment is a reality. The brain is molded according to what it has been provided with.

It all boils down to several basic points, which are as follows:

- If there has been a turning point for individuals with schizophrenia that have been treated with an approach different from the traditional methods, such as Psychosocial Rehabilitation, why do we not invest our time and resources into researching this approach?
- Even though it seems that a Psychosocial Rehabilitation type of approach is time consuming, expensive, and intense, we can still provide our clients with genuine support, guidance, and the positive regard that they need to succeed.
- One thing to take into consideration is that if these cases are successful, the therapist, and the mental health professionals involved, have a high intuition and generously gave themselves to their patients, and that this giving of themselves was the real turning point of the clients from the illness.

In conclusion, I would like to encourage the reader to seriously take into

consideration the points presented in this thesis. It is very important to understand that by introducing the reader to Symbolic Realization, it does not mean that this technique is the only valuable type of Psychosocial Rehabilitation. It means that the reader has been provided with another tool to help individuals with schizophrenia recover from the illness.

Although schizophrenia is considered a pervasive illness with low rates of recovery, we still have hope. This hope is proven by empirical data that shows a higher rate of recovery for clients treated with a Psychosocial rehabilitation type of approach. As psychotherapy diversifies and we become technical eclectics (or multimodal), we can also borrow valuable concepts from Symbolic Realization to help our clients find the desired relief and recover from schizophrenia.

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Appendix A

The Diagnostic and Statistical Manual of Mental Disorders IV provides a more developed and detailed symptom list (DSM IV, 1994, p.285-286). As long as the symptoms are not related to other conditions, the diagnostic criteria is as follows:

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

- (1) Delusions
- (2) Hallucinations
- (3) Disorganized speech (frequent derailment or incoherence)
- (4) Grossly disorganized or catatonic behavior.
- (5) Negative symptoms, i.e., affective flattening, alogia, or avolition.

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully

- treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual symptoms, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- D. Schizo-affective Disorder and Mood Disorder with psychotic features have been ruled out because either (1) no major depressive, manic, or mixed episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.
- E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another pervasive developmental disorder, the additional diagnosis of Schizophrenia is made known only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Author's Note

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This literature review was written as an honors thesis and for the need to find reliable alternative treatment for schizophrenia. On the basis of past and new published research the writer assumed that the present thesis has face validity.

The author thanks the thesis committee for their support and patience in the process of writing this thesis, since a great amount of information was translated by the author from French. The author took great care in representing the original research material accurately, so the original authors were not misrepresented.

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