Intensive care model for psychotic patients - Intensive growing for the therapist

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In the normal population individuals who carry genetic markers do not always develop diseases. Consequently, people can carry genetic markers of psychiatric diseases and live healthily if they solve all factors that triggered the disease, reversing symptoms. We have developed an Intensive Model with excellent results, where patients recouperate to normal life either by studying or working. Everybody, including therapists, grew and developed new healthy patterns.

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We developed an Intensive Care Model for treating psychotic patients based on the assumption: There are more subjects with genetic markers of mental illnesses than people suffering them. In fact, it is possible to live healthily for a lifetime despite having the genetic marker, and without exhibiting the disorder. Therefore we claim that psychotic patients can live without mental disturbances, even if they have the genetic marker, if we work through the factors that made the illness arise.

Integrative approach of different perspectives

We start by proposing different approaches to explain mental illnesses building alternative ideas and strategies to work with.

Psychiatry

From the *medical psychiatric approach,* mental disorders are viewed as chronic and irreversible.The main goal of treatment is to maintain stability and prevent relapse. The psychiatric patient is seen as unstable, fragile and needs to avoid stressful situations. The family must accept these facts and learn how to live with them in order to prevent and be able to manage crisis.

We think that this perspective maintains pathology as a self-fulfilling prophecy. If the family members try to keep the patient from dealing with stressful situations, this results on isolation from daily life situations, and information is withdrawn, increasing indirect communication and secrets.

One of our goals is that the patient, the relatives, and the team itself become aware that he or she can function and cope with stressors. In order to achieve this goal, we

seek the context in which the symptom is normal, as a way to apply the Ericksonian principle of utilization (Robles, 1991). We will talk about this later, when explaining the Ericksonian approach.

Human Communication Theory

Following the ideas of Bateson, Watzlawick, and others (1987), the permanent rejection of the content of communications, disqualification, and disconfirmation as well as the use of paradoxes and double binds, are seen as styles of communication in the families in which mental illness arises.

So, we suggest use of the following styles of communication with these patients: the acceptance of the content of their communications, to qualify and to confirm them as well as to establish a clear and open communication and a therapeutic double bind in a way that whatever they do or do not do is *ok* as long as they don't hurt themselves or others.

Systems Theory

Rigid families, according to M. Andolfi and colleagues at the school of Rome, and families in schizophrenic transaction, according to the group of Milan, show the following characteristics:

- Function with rigid and recursive patterns.
- Do not allow the individuation of their members.
- Have almost impermeable boundaries to the external world because it is seen as dangerous.
- There is no definition of the relationships (no one dares to express their will).
- There are family secrets.
- Covered symmetry with apparent complementarity.
- There is only one place for the one who is right.
- Double bind communication.
- Continuous search for confirmation without the possibility of getting it.

In order to untangle this, we propose to:

- Function rigidly flexible.
- Allow and encourage individuation.
- Offer at the beginning a safe and warm external world (the group and the clinic).
- Promote the definition of the relationship, that means, staff and patients talk about our own desires, fears and dreams.
- Work through family secrets.
- Establish an horizontal relationship: all we are equal even if we play different roles. For this reason, we, as therapists, are also used to talking about our emotions, anecdotes and everyday problems.
- Show that it is possible that all of us can be *ok* at the same time.
- Communicate in a clear way, always confirming the patients and their relatives.
- We work as a team in order to make everyone's dreams come true.

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Anthropological approach

According to Jean Piaget, by ten years of age we complete our neurocognitive development that allows us to analyze, criticize and accept or reject the information we receive. All the inputs before that age are unconsciously absorbed and this process remains also unconscious. We learn to see reality as if it were divided in opposed, contradictory halves:

Light - darkness, good - bad, spirit - matter, mind - body, intellect - emotion, logic - intuition, etc., and to consider the first part of the dichotomies as "first class" and the later, as "third class", worthless, thus, they are to be neglected or at least controlled by the former.

Consequently we learn to believe that our physical needs and emotions are wrong and undesirable, so they would have to be neglected and controlled. As this is impossible, we feel guilty and hopeless.

In our occidental world where a jewish-christian ideology prevails, we grow up while learning, absorbing the ideas that love is sacrifice; only what takes a lot of effort is worthy (no pain, no gain); first of all, obligations, afterwards, fun; there can only be a First Prize and we have to compete instead of collaborating with each other, among other injunctions that tie us inside social double binds, building the culture of suffering.

The human way to learn is by trial and error. But in the quest of becoming the winner, we deny and keep our mistakes to ourselves, and desperately, try to become the ideal person, who does not exist. This way, we lose the chance to learn from our mistakes and worst of all, we hopelessly maintain the illusion of reaching the place of the winner, with a hidden, internal certainty that it is not possible.

We constantly search for confirmation and recognition from the others, but they neither know how to do it, nor always want to do so. We beg or demand imperatively an "absolute unconditional love" that does not exist.

We believe that only by reaching "the ideal", we will be entirely accepted and loved. We make our best effort for loving the other in the way we think is right and we feel disappointed when the other does not love us as we want to be loved. This is not possible, because everyone loves as they can. Tremendous effort is wasted trying to be as "we must be" instead of simply "being". Thus, we turn the relationships into obligations, instead of considering them as opportunities. An opportunity to receive from each person a unique personal treasure.

We don't recognize who we are, alive, complete, with a feeling body, with emotions that reflect what is happening in the outside world that influence us, with desires, dreams, values and a personal epistemology. Instead, we try to find in the gaze of the others who we are, if we are *ok*, and so we behave from the roles we play, and learn to design and wear masquerades, which have a script that dictates how we must react in every moment and circumstance.

Psychosis can be seen as a failed attempt to escape from the *must be* in order *to be*.

Holographic paradigm

The modern physics has several assumptions useful for the work of psychotherapy, two are especially important:

The universe works as a hologram (Bohm & Peat, 1998), this means that the reality we perceive is a projection of something else. Furthermore, each part of the hologram contains the information of the whole, as each cell contains the information of the whole body. Therefore, it is possible to create (to clone) a complete organism from a single cell.

There is a subquantic field that fills the empty space (Lazlo, 1997). Everything that our brain processes, as a receptor, transductor and transmitter, is registered in this subquantic field. Memory is located in this field, out of our bodies. Every time we need bits of data these are retrieved from this pool that becomes in this way the storage of every bit of information, experiences, ideas of the whole humanity through time. This could be an explanation for the collective unconscious proposed by Carl G. Jung (1997).

Every person can retrieve his memories because each individual has a particular bandwidth to record and to access the subquantic field. Some individuals have a bandwidth broader than others. We propose that psychotic patients have an expanded bandwidth, especially during crisis, as wells as mystics known by their ability to open their perception.

One of our patients, Lucía, after she left behind a catatonic state, told us how she got caged in herself during two years: "I was taking a shower, washing my hair and I felt my head as a rose, I was scared, then, I looked at the wall and I felt my body as made of concrete. I become more frightened as I listened to the thoughts of the cat, I told myself that I was going to die, but I didn't want to, I looked at the clock; time stopped and I was suspended in time." The axis of therapeutic work with Lucía was to give her an explanation regarding the holographic paradigm and help her to return this information to the subquantic field and to readjust her bandwidth. Lucía improved clinically and was able to regain her functioning.

Ericksonian approach

Erickson had many resources to learn from, his work is so rich that gave birth to several schools of psychotherapy (NLP, strategic, brief, solution focused, to mention a few) and enriched many more (systemic therapies, hypnotherapy, hypnoanalysis, etc.) We are going to address here only to those, which are more relevant for this model.

Inner resources

According to Milton H. Erickson we all have the internal resources for solving any difficulty of life. We have a Wise Part, which for him is our Unconscious Mind. We consider this Wise Part something more than the Unconscious, and we call it "*I am*". *I am* is my essence, my identity. When we say *I am* we are confirming ourselves. I AM is related to our identity. *I am* is also one of the seven sacred names of God in Hebrew. It

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is the name for our Inner God.

We have developed a model for hypnotic conversation centred in the concept of the *I am*, for:

- arousing our Inner Wisdom and our Inner Resources and those of our patients,
- strengthening our identity and the identity of our patients,
- confirming ourselves and confirming our patients.

Every single communication among patients, their relatives, therapists and people working at our Center begins by *I am*.

As we mentioned before, we constructed the reality that even psychotic patients can be healed, can work and function as we do. However, we declared ourselves unable to cure them and we put the work in hands of their Inner Wisdom, the *I am*.

Normalization and utilization

Erickson was a master of using symptoms and "resistances" as tools for helping people. Symptoms were reframed from a different context and so utilized for promoting change.

Erickson once met a patient in the mental hospital telling people he was Jesus. Erickson told him that as a mankind helper he could smooth the dirt on the tennis court for the doctors to play tennis using the muscles God gave them. The man became an excellent tennis court keeper. Later, Erickson mentioned that the man was a carpenter (as Jesus was). Having nothing but to agree with the idea, accepted the task Erickson proposed serving mankind again, building book-shelves for the psychology lab. In this way, the man became engaged in productive activities (O'Hanlon, 1990).

Theresa from Avila (1971), the great mystic and Saint wrote on her book *Las Moradas del Castillo Interior* that when we reach the fifth dwelling of Our Inner Castle we begin to hear voices. She states the importance of distinguishing between the voice of God and the voices of the evil. The former evokes peace and calm, are brief and clear sentences, staying in the mind. The last ones are confusing, redundant, and generate fear, anxiety and guilt. From this perspective, therapy in patients with auditory hallucinations can be focused on developing the ability for listening to the voice of God and get the message in peace, instead of being persecuted by the voices of evil.

We asked Lucía, the former catatonic patient we talked about before: You know Saint Francis of Asissi used to talk with animals. Why he is seen as a Saint and why are you considered to be crazy? She answered that because Saint Francis didn't get afraid of that.

The delusions and hallucinations are beliefs and perceptions that are considered abnormal in some contexts, can be considered normal and even worthy in other contexts (review the comparison between an hindu saint and an hysterical patient from La Salpetrière; Clément & Kakar, 1993). We have found that in some of our patients these symptoms correspond to the perception of "energetic phenomena" well known by healers. We have also found that this kind of perception is especially fine-tuned during psychotic episodes. Some patients perceive the same auras, energies, shadows and

colors observed by an allegedly trained healer.

Peter, a patient with the delusion that his energy was being stolen by people around him was interviewed by a healer who explained to him that we have in our body, points through which energy enters and leaves (chakras). He realized, that what he interpreted as a robbery of energy was a perception of a normal flow of energy. When the patient's own way to explain to himself his beliefs is enriched and a new context is given in another framework, it gets normalized. From another point of view, we are utilizing the symptom to untangle delusions and hallucinations.

From all these approaches, we propose a three-stage model for moving from what I must be to what *I am*.

General outline of our work

- Any activity started is left in hands of the *I am*, of the patient and the therapist. In that way the *I am* becomes the leader of the work.
- All the verbalizations start with *I am* .... It consequently produces: confirmation, definition of the relationship, reinforcement of the identity, and allusion to the Wise Part.
- Continuous confirmation of the patient: accept what he says or does, as long as it does not harm him or others.
- Encourage them to define the relationship and to talk about their dreams and desires. It is a task for the group to create the conditions for making these dreams and desires come true. The father of a patient living at the shore of the Gulf of Mexico expressed that he felt the group as the warm family she never had, and her dream was having all the participants at her home dancing and having fun at the beach, immediately the group organized a trip for the very next weekend. This patient has a DSM-IV diagnosis of schizoid personality and persistent asthma attacks and atopic dermatitis. She had spent two years in an individual psychotherapy with poor results before she entered this program. After five months of treatment, she returned to school and to her town with no symptoms and a significant improvement in peer group relations and family interactions.
- Relate everything to natural processes and situations, as in the case of Lucía and Peter.
- Point out the positive side of things and incorporate this as a part of the verbalizations. If patients, therapists or members of the team say something negative about anything, they have to add a *positive but* to it.
- We adopted a horizontal leadership and participate as members of the group, utilizing our own life experiences and emotions as inner resources. We decided to confirm patients; every single moment given the condition that no one hurts himself or others establishing a therapeutic bind.

From these assumptions and approaches, we work full-time with hypnosis techniques in group, individual and family therapy sessions in three stages.

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FIRST STAGE (three months)

- Initial psychiatric evaluation.
- Application of scales: Well Being Index to the patients, relatives and therapists.
- Structured group sessions using verbalizations from the I AM. Family members are invited to participate. Every session is conducted by two therapists, where there is a topic to work on. We actively prevent the emergence of personal narratives that are worked in individual sessions. From the beginning to the end of the session we work with exercise in dyads modeled by the therapists. We conclude every session with a hypnotic trance induction.
- Individual and family hypnotherapy sessions.
- Sessions of enacted metaphors involving every member of the group.
- Psychoeducational sessions about How the problems emerged (our own approaches) in which the patients, their relatives and the students in our training program participate together.

SECOND STAGE (two months)

- Patients and their families coordinate activities for the new patients and get a payment from the Institution.
- Patients become part of the regular hypnotherapy groups of the Clinic.
- They continue having some individual or family hypnotherapy sessions, depending on their needs.
- They may ask for a group session where a specific topic, suggested by them, is developed.
- We make agreements with all the members of the group in order to make everybody's dreams come true.
- Second psychiatric evaluation.
- Second application of scales: Well Being Index to the patients, relatives and therapists, at the end of this stage.

THIRD STAGE (variable duration)

- Gradually, patients start working outside the clinic.
- Individual or group hypnotherapy sessions.
- Patients participate coordinating activities in the groups of new patients.
- Third psychiatric evaluation.

Results

At the start of the program we considered as "patients" only 8 people. As the work unfolds we discovered that 12 of their relatives also showed severe disturbances and considered themselves as patients.

Then we had a sample of 20 subjects, 12 women and 8 men, with an average age of 30 years, and average time of evolution: 16.2 years, with the following diagnosis: 5

schizophrenia, 8 borderline personality disorder, and 7 schizoid personality disorder, narcissistic and dependent personality disorder. There were other relatives involved in the treatment.

Every participant showed a significant improvement in the Well Being Index (WBI) evaluation.

The statistical analysis were done with Wilcoxon test using SPSS software with a significant increase in WBI with a $p<.006$.

Other results reported by the patients on an open questionnaire and observed by us were: the sense of belonging to a "new family", the developing of a supporting social network integrated by the group and the Center. From the group new projects and initiatives for doing things together emerged.

Staff members (non-therapists) reported they overcame the fear of madness and severe disturbances of personality.

The fact of giving the leadership of the work to the *I am* and the results, made us, as therapists, gain humility and hope and it increased our ability to be astonished. We also discovered a light and agreeable way for working with severe disturbances.

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Effects and changes on the therapist's personality during hypnotic-psychotherapy training

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The goal of this paper is to explore some dynamics that might develop in the experience of hypnotherapy training. The data derived from our investigation show that a meaningful percentage of hypnosis students tends to delay or leave the professional use of hypnosis. A reason for this form of fugue from hypnosis can be identified in the fact that at the end of the training program, most hypnosis students suppose to master the hypnotic techniques. In fact they find themselves in an apparently safe mental phase, we have called "apparent mental phase". Later on, when they get in touch alone with a real therapeutic situation, the strong emotional impact produces a mental phase we might call "shock mental phase". It is this phase that can lead the new therapist to leave or postpone the use of hypnosis. The "fugue from hypnosis" is generally unconscious, so that the students prematurely leave their training without any "apparent" motivation. Only through the deepening of the hypnotic state and the intensification of the emotional exchanges between student and supervisor, a mental phase we have called "overcoming mental phase" develops. This phase allows the student to overcome the experienced "shock", and to reach a more functional syncronicity and integration of both the rational and emotive mental processes.

The starting point of our research was the observation that a high percentage of hypnosis-therapists often abandon such a technique in favor of other forms of psychotherapy. Since the student seems to abandon his/her training without any apparent reason, we maintain that the cause of this abandonment may lie in the strong emotive impact it has at a personal level, and that the phenomenon occurs unconsciously.

Recently a number of studies (Walling & Baker, 1996; Elkins & Wall, 1996; Yapko et al., 1998; Watkins, 1998) on the spread and results deriving from teaching clinical