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Editor's Message

Work and love in the time of COVID-19 has been the subject of much discussion since the pandemic has gripped our country starting early in 2020. The pandemic has fundamentally changed the way that clinicians and patients alike work and love. Individuals have unique ways of responding to the circumstances of the pandemic. News stories abound about despair due to deaths of loved ones from COVID-19, financial ruin, domestic abuse, child neglect, and relapse on substances. Certainly, these social crises are not to be ignored. However, there is another side to the pandemic as well (of course this is a function of the most basic layers of Maslow's hierarchy of needs being met.) Some people have been prompted by the environment to become more reflective now that some of their usual means of distraction are unavailable. Some people have become more willing to face inner conflicts or external deprivations and moreover, to do something about them. Some people who are fortunate enough to have warm and caring social connections have become more proactive and deliberate in tending to them.

On the note of "working and loving in the time of COVID-19", I would like to call on all ASPP members to lend a hand in tending the garden that is our community so we can stay connected and flourishing during this unusual time. Many hands make light work. I am particularly seeking bulletin contributors, CME program and journal club organizers. Please contact us at amsocpsychphys@gmail.com if you are willing to nurture our Society by fulfilling an aforementioned role.

Aileen Kim, M.D.
Co-Editor

Message from the Executive Director

Welcome 2021,

I hope that everyone is staying safe and that you and yours are well. 2020 was such a difficult year for so many Americans and people all over the world.

Many of our members have had to step up is many different capacities during the past year. So, with that in mind, I am writing to all of you to which of the many members of the ASPP might be willing to step up and help with a few duties. It would not require very much time form any one individual. Right now, a couple of our members have been carrying the load and now need to step back a bit. Please contact us at amsocpsychphys@gmail.com if you have time to manage the Bulletin or to help with meetings.

Thank you in advance, and I wish all of you a safe new year.

Christine Cotter
Executive Director

Understanding Schizophrenia and Proposing and Defending a Treatment

Wilfried Ver Eecke*

Introduction

In this paper I will start by mentioning the successful treatment method of "Open Dialogue" in Finland, the flexible psychosocial rehabilitation program in Vermont and the results of Pekka Tienari's twenty years study of children of psychotic mothers to demonstrate that severe mental illness, like schizophrenia, is not predominantly a genetic disease, but a development deficiency which can be helped and even cured by appropriate therapy. Next, I make use of Lacan's theories to provide a psychological explanation of severe mental illness, including schizophrenia. In the rest of the paper I present and analyze Villemoes' method to treat patients suffering from schizophrenia.

I. Contradictory views of Schizophrenia.

World-wide, 0.009% of the population is afflicted by schizophrenia. In October 2020, the world population is estimated at 7.8 billion. Thus about 70,200,000 people world-wide can be expected to be afflicted by schizophrenia. With a population of 331 million people, the US can be expected to statistically have 2.979 million people suffering from schizophrenia.

In DSM-V-TM we find the following statement about schizophrenia: "There is a strong contribution for genetic factors in determining risk for schizophrenia, although most individuals who have been diagnosed with schizophrenia have no family history of psychosis" (DSM-V-TM, 103). The first part of this statement formulates the belief that schizophrenia is strongly determined by genetic factors. The second part of the statement reports a fact contradicting the stated belief: i.e., most people diagnosed with schizophrenia have no family history of psychosis.

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Upon this belief, contradicted by the reported facts, the American psychiatrists in their PORT reports recommend that schizophrenia be dealt with by lifelong medication. (Lehman et al. 1998; 2004; Dixon et al. 2009). Such medication has potentially serious side effect like dyskinesia.

In Finland, Seikkula and his co-workers developed a successful method to treat and heal persons afflicted with schizophrenia. Their method consists of the "Open Dialogue" method (Seikkula et al. 2003; Seikkula et al. 2006). The "Open Dialogue" method starts already with a different approach at the moment the patient has a schizophrenic breakdown. Three mental health professionals go to the house of the patient. They do not hospitalize the patient. Instead, the three professionals talk to the patient and his or her parents. As the first schizophrenic breakdown occurs mostly in the late teens or the early twenties, the patient is often still living with his or her parents. These mental health professionals let the patient and his parents explain what they like to say. Then the three professionals talk to each other and ask the patient and the parents what they picked up from the conversation. At first, they do this every day; then every week; then every month. Seikkula reports that after five years of such therapy "Eighty-two percent did not have any residual psychotic symptoms. 86% had returned to their studies or full-time job, and 14 % were on disability allowance" (Seikkula et al. 2006).

Harding reports that, in Vermont, a program was developed for persons afflicted with schizophrenia. The program was a flexible psychosocial rehabilitation program which included letting patients do farm work. "62% to 68% were found to be significantly improved […] or to have completely recovered" (Harding 2002). Helping mental health patients, even severe mental health patients, to find work, they can and want to do, is a very constructive approach. We know from Hegel that work allows a human being to transform objects according to a mindful plan and to do so with the help of his/her body. The results of work become an objective testimony of the person's power of his/her mind (Hegel 1977, 118-19). Helping persons afflicted by schizophrenia to do work is therapeutically a healing intervention.

The research of Pekka Tienari and his group also demonstrates that environmental factors dominate, whatever biological or hereditary factors might play a role in causing schizophrenia. Tienari checked, for twenty years, all the women who had been hospitalized for schizophrenia or paranoid psychosis. He checked which of those women had had children, given up for adoption to Finnish non-family members. He then looked at the adopting families. Tienari divided the adopting families between families that were judged to be either healthy, or neurotic, or were judged to have personality disorders or to have functional psychoses. Tienari found that not one child of a psychotic mother, who had been adopted by a healthy family, developed a "functional psychosis" (Tienari 1992, 163). Tienari's research comes to the hopeful conclusion that the environment dominates the genetic and thus the biological predisposition. People afflicted by schizophrenia or psychosis are, therefore, not condemned to life-long suffering. They can be helped. They can even be healed.

II. Lacan's Theory of Severe Mental Illness.

We have to wait for Lacan to provide a theory which gives a psychological and not a biological explanation of schizophrenia and psychosis. In his doctoral thesis (Lacan 1932), Lacan connected all the symptoms of a paranoid patient, Aimée, to her personal life experiences. Lacan made his first international contribution with his theory of the mirror stage, presented at the fourteenth International Psycho-Analytical Congress in Marienbad July 31, 1936. But it took until 1949 before Lacan published his ideas on the mirror stage (Lacan 1949). In his theory of the mirror stage, Lacan points to the fact that the child originally experiences itself as consisting of body parts: a mouth to be fed, a hungry stomach, a bottom to be cleaned. Only at about six months does the child create an image of itself as being a unified body. Indeed, around the age of six months children show great delight when seeing themselves in the mirror. They not only smile, but joyfully move their arms and stand and jump on their feet, so much so that parents need to hold on to the infant, if they put the baby on a dresser with a mirror.

Later Lacan drew attention to the fact that the baby, when looking at its image in the mirror, pays close attention to the eyes of the mother who holds him/her (Lacan 2006, 55-6)[5]. In seeing the pride of the mother looking at the child recognizing itself in the mirror, Lacan points out that the child borrows from the love of the mother the love used to love its own bodily self. In the absence of motherly love, we can thus predict that the child's body will not develop normally.

We find confirmation of that theoretical conclusion in the research of Spitz. He reports about 26 children in a Foundling Home, ranging in age from 18 months to 2 ½ years. As they were given up for adoption, they had been lacking a mother. Of those 26 children only 3 could walk, even though they were between the ages of 18 months and 2 ½ years (Spitz 1945, 59). Spitz even reported that, in one of the great foundling homes in Germany, the mortality during the first year of life was 71.5%. So, the lack of maternal care led not only to retardation in the development of the body, it led to excessive mortality (Spitz 1945, 53; Spitz 1965, 267-84).

People suffering from schizophrenia report a loss of feeling of bodily unity, as was the case with Judge Schreber. Indeed, Judge Schreber, during his psychotic period, felt that he once had another heart, that his lungs were almost completely eaten up and that his stomach was often taken away (Schreber 1988, 151-2; Ver Eecke 2019, 6-7). Lacan's theory of the mirror stage provides the theoretical basis to explain the feeling of bodily disintegration by schizophrenic patients. Lacan sees such feeling of bodily disintegration as a regression to a period before the mirror-stage period and its achievements.

In 1938, Lacan published an article for the "Encyclopédie Française" entitled "The Family Complexes in the formation of the individual. Analytic paper of a function in Psychology" (Lacan 1938). In that paper, Lacan argued that the child goes through three different stages in its early development. He gave two of those stages a different name than Erikson and even Freud. Lacan called the first stage the weaning complex, not the oral stage (Freud) nor the stage of basic trust vs basic

[5] I am grateful to Dr. Devra Simiu for this reference.

mistrust (Erikson). Lacan called the second stage the intrusion complex, not the anal stage (Freud) or the stage of autonomy vs shame and doubt (Erikson). Lacan gives his third complex the same name as Freud, i.e., the Oedipus complex. It differs from the name given by Erikson to his third development stage; initiative vs guilt. Lacan stressed that failures in dealing with the challenges of these three complexes makes the child, later in his/her life, vulnerable to mental illness.

In 1955-56 Lacan gave his weekly seminar on the topic of psychoses (Lacan 1981). Lacan published his crucial insights of that seminar in the path breaking article: "On a question preliminary to any possible treatment of psychosis "(Lacan 1958; 2006).

In that seminar and that article, Lacan discusses the case of the schizophrenic Judge Daniel Paul Schreber in detail. Lacan could rely on Schreber's own autobiography. Daniel Paul Schreber was the Chief judge at the second highest court in Germany under Bismarck. He had originally opted for a political career, but had been defeated in his bit for election, which resulted in Schreber developing hypochondria. This required a six-month stay in a Leipzig clinic (Schreber 1988, XI). He then developed a very successful legal career, leading to his appointment as President of the Senate at the Dresden Superior State Court.

But D.P. Schreber had an unfulfilled wish. He wanted children. However, his wife had had five or six miscarriages (Schreber 1988, 63). So, the hope of Judge Schreber to have children was crushed. To deal with this crushed desire Schreber was not able to mobilize the power of mourning. Instead Schreber created a delusion. He imagined that he was becoming a woman, in order to marry God and to create a new mankind where he would be the patron saint (Schreber 1988, 117, 119, 212 and 214). In his autobiography he gave as proof that he was becoming a woman the fact that "my breast gives the impression of a pretty well-developed female bosom: this phenomenon can be seen by anyone who wants to observe me with his own eyes" (Scheber 1988, 279-80).

In his delusion, Schreber did not receive a child from his wife; he became himself a woman who produced children. He got the children by marrying god. His progeny would create a new

mankind. In that new mankind Schreber would be honored as the patron saint. Hence, the delusion over fulfilled his wish. Furthermore, the delusion satisfied his grandiose narcissism in that he married not just any desirable partner but God. He did not just have a child. He created a new mankind. He was not just respected by his progeny. He was made their patron saint.

Lacan explained the schizophrenic delusions of Daniel Paul Schreber by claiming that something was missing in the psychological development of Schreber. What was missing was "the paternal metaphor" which provides human beings with a new signifier: "the Name-of-the-Father" (Lacan 2006, 479). We are now invited to explain what Lacan means by paternal metaphor. As the relationship of the child to the father is preceded by the relationship to the mother, we will start with presenting the relationship of the child to the mother.

Children develop a psychic structure in their relationship with the first all important figure in their lives: the mother or the mother figure. At birth the human babies are totally dependent upon a mother figure. However, human babies have a consciousness. And for a conscious being total dependence is unacceptable. Still, it remains a fact that the human baby is totally dependent upon a mother figure.

The question now arises as to how human beings deal with unacceptable realities. One important strategy is the use of imagination, in which human beings create an alternative acceptable reality. This is also what happens with babies. In order to deal with their unacceptable total dependency upon another, the babies create two fantasies. First, they imagine that their mother is omnipotent and perfect. Otherwise, they would not be safe. This imagination remains part of the unconscious beliefs as illustrated by the attitudes and beliefs of teenagers. Thus, teenagers are known to criticize their parents, including their mother. However, if someone else criticizes their mother for the same reason as the teenager does, then the teenager often will defend his/her mother. Hence, the critical teenagers retain an ideal image of their mothers.

The second fantasy created by the child is that the child imagines that it is everything the parent would want. Thus, when my wife read in the newspaper that there were few children in Germany, where we had been for a sabbatical year, one of my children asked in a concerned manner: "why are there so few children in Germany?" My wife provided a common-sense answer and said: "I guess those German parents believe it is too much work." My son responded: "But do those German parents not know that it are the children who do all the work?"

If the children have these two fantasies, they flourish. But if those children were to keep this narcissistic image of themselves as adults, they would not be desirable partners. Thus, something must occur that changes the original psychic attitude of young children.

A first important step occurs around the age of 15 months. A big change occurs in the life of a young child when it starts to crawl or can start walking. But this means that the child is out of the physical reach of the mother. Still, when crawling or walking the child can brake things or hurt itself. Hence, the mother has to reach the child by speaking and saying constantly "no". But this frustrates the child. The child expresses its frustration by using the word that imposed frustrations on the child itself. [6] By regularly uttering the word "no" to the mother, the child aggressively separates him or herself from the mother (Ver Eecke 1984, 64-70; 2006, 82-87). This move makes the child ready to pay more attention to other people, in particular the partner of the mother, which is mostly the father (Id., 78-84).

The child now starts to see that the mother has an interest in that other person. This observation destroys the two original fantasies of the child. First, if the mother has an interest in another person, it must be that she does not have it all, that she lacks something (Leader 2012, 141). Second, if the mother misses something and she looks to her partner this means that "I" the child am not able to give the mother what she is missing. This destroys the second phantasy of the child and

[6] Spitz calls the mastery of the no-saying a great cultural achievement of children because it allows the child to express its frustration and aggression by the use of a word instead of having to have a tantrum (Spitz 1957, 150).

leaves the child with the question as who (s)he is or wants to be (Ver Eecke 1984, 83; Vergote 1964, 197).

The Lacanian suggestion is that the child looks at the signals of the mother which indicate to the child what it is in the mother's partner that is of such interest to the mother. The child then takes this mark or this characteristic in the partner as the basis of its own identity. The child realizes that it is not yet like the father. Hence, the child takes the future as the most important dimension of time. The child also accepts that it will have to work in order to become like the father. Finally, it will have to develop patience (Ver Eecke 1984, 182-3).

If we look at this process we can conclude with Lacan that the child has developed a totally different psychic personality. Still it remains the same child, say: John Percy. We are aware that there are words that have a second meaning which is the same and not the same. Thus, when I say to a person that he is a chicken, I understand the literal meaning of the word chicken which I do not reserve for the person which I call a chicken. The word chicken, applied to a person, has a second meaning derived from the attitude of chickens who run away as soon as they see danger. This characteristic refers to being a coward. This second meaning is called a metaphor.

In developing a totally different psychic structure by identifying with a mark in the father, while remaining the same child, John Percy, Lacan claims that the child has made a metaphor move. As that metaphor consists in identifying with a mark of the father Lacan calls the psychic move of the child a paternal metaphor or more specifically the metaphor of the Name-of-the-Father (Lacan 2006, 464-5; Grosz 1990,103-5; Evans 1996, 137)

The paternal metaphor consists of introducing a third in the life of the child. In a Lesbian couple this third is the female partner. In the case of a single mother the question becomes what can function as a third? It could be the dead father. If there is no recognized father, the mother is invited to look at what the child is good at and ask what the child will do with that talent in his/her life. The

mother is invited to make the skill of the child a third, rather than push the child to become what she wishes, like becoming a lawyer because her father was a successful lawyer.

If the mother does not introduce a third in the psychic life of the child then the two original fantasies continue to dominate the life of the child. Such fantasies make the child vulnerable to mental illness. This was the case of the great German poet Friedrich Hölderlin (Ver Eecke 2019, 188-190). Hölderlin's father died when the later poet was two years old. Laplanche and Pontalis report that Hölderlin's mother was so pained by the loss of her first husband that when her son, Friedrich, asked about his father, she could only answer with silence. In his teenage years he wrote beautiful poetry which was discovered by the established poet Johann Friedrich Schiller. Schiller helped publish the poems of Hölderlin and invited him to the weekly meeting with Johann Wolfgang von Goethe (Laplanche and Pontalis 1969, 38-9). Schiller thus played a protective maternal role in the early years of Hölderlin's career. Hölderlin then developed the idea of starting a journal. Given that in the past Hölderlin had experienced a maternal helping attitude from Schiller, Hölderlin expected and asked Schiller to finance his dream of starting a new journal. Schiller declined this request for help (Laplanche and Pontalis 1969, 84). Schiller hereby took on a new role, that of the father who puts limits. As Hölderlin was only able to deal with maternal attitudes of people he related to, Hölderlin did not have the psychic structure to deal with a paternal limiting refusal. This change from a maternal to a paternal attitude by Schiller led to Hölderlin's psychic breakdown.[7] He was sent to a mental hospital where he stayed for the rest of his life, visited by many German dignitaries (.

One of the typical symptoms of persons afflicted by schizophrenia is that they have difficulties with some aspects of language (Ver Eecke 2019, 8-9chreber 1988, 70 note 26, 121, 139-143, 151-6, 172-3). The future schizophrenic, in Lacan's understanding, has not made the psychological metaphor of separating from the mother and identifying with a mark in the father and thereby becoming psychologically a different person (Evans 1996, 111-13, 137-8). In not having made this

[7] For an analysis of what triggers a psychotic breakdown, see: Leader 2002, 170-94.

psychological metaphor, Lacan concludes that they are not equipped to understand linguistic metaphors. Rather they limit themselves to interpreting language literally. A Belgian psychoanalyst reports that a patient said that she had no hands. Asked by the therapist how she knew, the patient stated that her father had told her so that morning. To the question as what the father had said, she replied: "You are handicapped." The patient was Dutch and the word handicapped in Dutch literally states: "handicut" (Moyaert 1988).

III. Villemoes' Approach to the Treatment of patients Afflicted by Schizophrenia.

Villemoes, a Swedish psychiatrist, decided to develop a protocol, based upon the ideas of Lacan. His method is called "Ego-structuring Therapy" (Villemoes 2002). Let me describe this method. The method starts from where the patient is: i,e., the imaginary with an absence of the mastery of the symbolic.[8] The mastery of the symbolic requires, however, the mastery of the loss of mother/child relationship and the willingness to give up the two illusionary fantasies typical of the mother/child relationship.

The first decision made by Villemoes is the position of the patient and the therapist. Villemoes does not sit opposite the patient. Putting the patient in front of the patient is putting the patient on the spot. It assumes that the patient is an active agent, which a schizophrenic person is not. Therefore, he sits next to the patient, four feet apart, with a small table in between the patient and the therapist, in order to avoid homosexual or heterosexual feelings. Villemoes also makes sure that the patient is closest to the door so as to avoid the fear of the patient that the therapist might lock him up (Villemoes 2002, 646).

After a first session, in which the patient has explained his problems, Villemoes starts to describe the objects in the room in detail (Ibid.). Applying Villemoes' method, I described from the

[8] The idea tht the therapist must start from what the patient experiences and believes is also stressed strongly by Bertram Karon, a psychologist specialized in treating schizophrenic patients. Thus when a patient asked if his nightmares about his stepmother would disappear if he killed his stepmother, Karon answered: "The old bitch deserves to die, for what she did to you" (Karon &VandenBos 1994, 198)

second session on, the objects in the room. In the following session I described, for a whole session, the color and the figures of the rug in the room. This was my first case, where I applied the ego-structuring method. During the whole session, I wondered if I was providing the patient with any service. I did, as the patient himself explained.

The patient stated that when he looks at the world with his senses the world is infinitely rich. If he describes it in language, he loses the richness of the sensual world. This feeling of loss, when using language paralyzed the patient. The patient asked: "What am I supposed to do?" The patient also stated that he wanted to know everything, but he now realizes he cannot know everything. He asked again "What am I supposed to do?" In both cases the patient revealed that he, psychologically, could not deal with loss.

When I described the figures and the colors of the rug, I noticed, to my surprise, that this patient was more attentive than any of my other patients. I interpreted the intense attention of this patient as testimony that I did for him what he could not do for himself. Furthermore, in addressing this patient at the level of his psychological development and thus describing the objects in our joint environment, I might have given this patient, maybe for the first time in his life, the experience that he and another person live in the same world. Hence, his loneliness might have diminished.

Another rule of the ego-structuring method is that the therapist does not ask questions to the patient (Villemoes 202, 647). To ask a question is again to put the patient on the spot. It is assuming that he can be an agent in a dialogue. He is not. When one likes to have information of the patient, like how he comes to the consultation room, one does not ask the patient: "How did you get here?" Instead, one provides the patient with the topic one is interested in and the language that the patient needs to provide the therapist with the information the therapist is interested in. Thus, one can say: "Some people come to the consultation room by bus; others come by foot; others come by bicycle; others come by taxi." The patient might answer: "I came by the metro and then walked here."

Next, one encourages the patient to describe the objects in his/her own room, apartment or house (Villemoes 2002, 648). One encourages detailed descriptions such that, as therapist, one can visualize the space where the patient lives. Other things that the therapist can invite the patient to describe are the office space or the school of the patient. One can also include any space that is part of the daily life of the patient, like the soccer field or the library that (s)he goes to. Such descriptions of real objects help the patient to make use of language to describe the real world instead of using language to describe his or her delusions. This use of language to describe the real objects in the world allows the patient to accept and tolerate the loss that is involved in using language for describing the world.

In talking to a schizophrenic patient, the therapist, as we already mentioned, should not ask questions (Villemoes 2002, 647). But there are several others things the therapist should not do. The therapist should not use polarizing language such as contradicting the patient or using first and second person pronouns in an oppositional way (Villemoes 2002, 646). The therapist should avoid answering questions by the patient. Instead, the therapist should state that the patient's question is a legitimate question. If necessary the therapist should add that (s)he has similar questions. This allows the patient to see that other people have also unanswered questions and seem to be able to live with them. Finally, if the patient asks a question about the reason for the therapy techniques, the therapist should answer that he was instructed to do it that way. This answer allows the patient to feel that there are laws, that even the therapist accepts (Villemoes 2002, 647).

The schizophrenic patient has a hard time to accept any loss. As there is a loss involved in speaking because of the lack of identity between the words used to express an experience and the experience itself, the schizophrenic person has some difficulty to feel at ease in speaking. This is very well illustrated by the French poet Arthaud's consternation that the three words "it is cold" are not the same as the feeling of shivering of the body, when the body is exposed to the cold. Here are the words of Arthaud:

> If it is cold I can still say that it is cold, but there are times when I am incapable of saying it. This is a fact, for there is in me something damaged from the emotional point of view, and if someone asked me why I could not say it, I would answer that my inner feeling on this slight and neutral point did not correspond to the three simple little words I would have to pronounce ["it is cold"]. And this lack of correspondence, therefore, between a physiological sensation and its emotional response in the first place and next its intellectual response—insofar as it is possible to summarize and synthesize in general terms this series of swift, almost instantaneous operations which give rise to the truism *it is cold* –the lack of correspondence, since it does not select its subjects or spare me in any way, as it spreads, in the colossal troubles which correspond perfectly, alas, to the loss of personality. (Artaud 1976, 294-95).

Given the challenge that speaking represents for the schizophrenic person, it is important to mobilize as many motives to help the patient to speak. Given that, in the beginning of the therapy, the patient is asked to describe spaces (s)he is living in, (s)he receives narcissistic satisfaction. That narcissistic satisfaction leads to the development of transference (Villemoes 2002, 649). Before the transference starts to take the form of signs of love for the therapist, the therapist must move on to the second phase of the ego-structuring method.[9] That second phase is called the working phase (Villemoes 2002, 649). The working phase starts by the therapist telling the patient that they now will describe objects and sceneries in the earliest memory of the patient, like when he went to pre-Kindergarten. Also, the therapist delegates to the patient the responsibility to end the session. The delegation to the patient of the responsibility to end the session gives the patient an active role, even if this active role is minimal. This delegation also gives the patient power that is narcissistically satisfying (Villemoes 2002, 649-50).

The working phase is a big shift in the therapy. Instead of describing objects that are available to the senses, the patient is now asked to describe objects and sceneries that are available only to the memory of the mind. These objects and sceneries cannot be pointed to; they must be linguistically

[9] Villemoes gives the following signs as indicators that the transference is changing into love for the therapist: "The patient arrives by his own and on time, sits down in the waiting room. Smiles and arises quickly when the therapist invites him in. Looks at the therapist and seeks eye contact. Becomes sensitive to alterations in the room. Agrees with the therapist in everything. Uses the therapist's phrases on leaving. To sum up, for the patient the identification with the therapist changes the "owned" into the active "owns." In Lacanian terms, this is a transition from being an object, a being that is mediated through the contact senses, e.g., auditive hallucinations, to having objects, mediated by the distance inherent in vision. (Villemoes 2002, 649).

described (Villemoes 2002, 650). In describing these early sceneries, the patient normally starts to mention people connected with these sceneries (Villemoes 2002, 653). Thus, when describing the road to his pre-Kindergarten, the patient might mention that it was his older sister who brought him to school; that there were other children also going to school; that two were friends of his sister; that his sister always started to talk with those friends but still continued to hold his hand.

The patient will then start talking about the class room, the sitting arrangements and the teacher. The patient might then report whether he liked the teacher or not. When reporting on first, second or third grade the patient might report more interesting material like: "I was a trouble maker." The patient might then make a reflection like: "I wanted attention. I guess, I did not receive enough attention at home. My parents were often fighting and then divorced."

The purpose of the working phase is for the patient to talk about his/her history (Villemoes 2002, 650). By concentrating his questions on the objects of the past, the therapist is allowing the patient to freely choose when to comment on his/her relations with people. The patient might mention a traumatic event like a suicide attempt. At first, the patient might just mention the event without giving much explanation. In later sessions, the therapist can then bring up such traumatic events and ask the patient to tell more about the event. One can wonder with the patient what led to the event, what the patient remembers of the event, what other people were involved or witnessed the event and what reactions the patient him or herself had emotionally or intellectually to the experience of the event.

In all these interventions the therapist should not make any judgements.[10] The task of the therapist is to encourage the patient to put in words what he or she experienced. By inviting the patient, first, to describe the objective circumstances, the therapist invites the patient to put simple things into words. Once the patient is in the process of putting things into words, the patient is mobilizing his/her

[10] Bertram Karan too stresses that the therapist should not be judgmental, not even about the murderous feelings of the patient (Karon & VandenBos 1994, 198).

capabilities to talk and can then be encouraged to describe things, like emotions, which are more difficult to describe.

An important consequence in the strategy of inviting the patient to describe the objects (s)he remembers and the personal relations connected with them is that the patient starts to make, unconsciously, a picture of his/her ego as it appears through the report of his history. The patient experiences that picture with sadness as he discovers that his/her ego was passive, not active. In other words, the patient discovers that (s)he did not have projects. This experience of sadness indicates that the patient is incorporating in his/her psychic structure the feeling of loss. Villemoes sees this experience of loss as the equivalent to the feeling of loss that accompanies the normal experience of the Oedipus complex of which the schizophrenic patient was deprived.

The feeling of sadness experienced by the schizophrenic patient, when seeing his reported and reconstructed history is a great success in ego-structuring therapy. It is the moment that will invite the patient to actively introduce the future in his/her experience of time. It will invite the patient to create an ego-ideal which will encourage him/her to accept that the ego-ideal is not yet real and will require work to get there. As the patient accepts that the ego-ideal is not yet realized the patient will have to develop patience (Villemoes 2002, 654).

The second phase of the Ego-structuring therapy method aims at increasing the psychic structure of the schizophrenic patient. Villemoes reports several signs that indicate the increased psychic structure of the patient. One sign of improved structure in the patient is the fact that the patient starts showing that (s)he is not certain of past events. Thus, the patient might say "My brother was born in 1976 – or was it 1977?" (Villemoes 2002, 652).

A second sign is the fact that the patient makes linguistic associations, like saying "By the way" or "That reminds me…" or "Speaking of this…". This shows that the patient is not just any more stimulated by external event. The patient makes linguistic connections (Villemoes 2002, 652).

A third sign of increased structuring of the patient's psyche is the fact that there appears a modulation of the patient's speech. The modulation of the voice is an instrument to communicate meaning to the audience. Such a modulation is absent in the voice of the psychotic. The speech of the psychotic is monotonous (Villemoes 2002, 652).

A fourth sign indicating an increased structure in the psychotic patient is the change from a rigid body to subtle body movements. This indicates a growing connection between the interior body with its desires and motives and the exterior body expressing those desires and emotions (Villemoes 2002. 652).

A fifth sign of the progress in the therapy is the fact that the patient starts showing interest in the environment. He/she might ask if that painting on the wall was there the week before. He might ask the therapist if he has to close the door when he leaves the office. Villemoes interprets this sign as an indication that the patient starts to experience him or herself as an agent. The patient acts as if he is not just an object next to other objects. He behaves as a person who actively sees and can create his or her own world (Villemoes 2002, 653).

A sixth sign of improvement is the fact that the patient becomes capable of empathy. They say something like: "It couldn't have been easy for mother to look after so many children." For a psychotic person empathy is a challenge. They are psychologically in the situation of the baby or young child who attaches and clings to the mother. The mother, and also any other person, are not really another person. They fuse with the others whom they encounter. That fusion is very well known to child psychiatrists. Often the symptom of a child is the symptom of another person's dilemma (Villemoes 2002, 653; Mannoni 1972). Empathy shows that the patient is able to relate to other loved people as different. It shows that they can even do the work of imaging how the world of the other is.

A seventh sign of improvement of the psychotic patient is the fact that persons appear in his report of his own history. On top of that, persons appear which are centers of their own opinions. Family members get a life of their own (Villemoes 2002, 653). This is different from what we learn of

psychotic Judge Schreber who talked about other people as “fleetingly-improvised-men” (Schreber 1988, 113-6, 143 and 288).

An eight sign of improvement of the psychotic patient is the appearance of self-reflection. Villemoes identifies two forms of self-reflection. The first is a historical one such as: “I used to listen to my parents in every matter, nowadays I seldom do.” In this case the patient becomes aware that he has changed over time. The second self-reflection presents an awareness of an ego-ideal like when the patient says: “I am not a shop-lifter” (Villemoes 2002, 654).

A ninth sign of important progress of the psychotic patient is the fact that the patient is able to compare his actual life with his ideal-ego or his ego-ideal. He realizes that he has achieved little in his life of what he could have achieved. This is only possible after the patient starts to experience the difference between his real situation and his ideals. This results in the patient becoming sad. Villemoes considers this sadness the equivalent of the child’s experience of castration in the Oedipus complex (Villemoes 2002, 654).

The tenth sign of improvement is the phenomenon that the patient starts to introduce a new dimension in his speech. He looks at the speaker to see if the meaning of his words reaches the audience. The patient accepts that the meaning of his words depends not only from him or herself but also from the listener. (Villemoes 2002, 654).

The eleventh and last sign of improvement of the psychotic patient is the fact that the patient starts to take the future into account for his present decisions. Thus, the patient realizes that there are connections in the world. He realizes and accepts that if he wants to go to college, he will need money to pay for tuition and other expenses. Hence, satisfying his desire to buy a car is not acceptable. By incorporating the future in his present-day decision making, the psychotic patient makes him or herself capable of repressing some desires that do not fit in his or her future plan (Villemoes 2002, 654). That the previously psychotic patient becomes capable of repression of some desires in favor of a future plan means for Villemoes that the therapy succeeded in structuring the patient. Villemoes believes that

the reconstructed history of the patient performs the role of the third, which in the Oedipal complex is performed by the father or the partner of the mother. The role of the third is to create the primal repression of the attachment and fusion with the mother figure (Villemoes 2002, 654). If the primal repression has been installed, then the working phase of the ego-structuring therapy has achieved its goal, provided there are no gaps left in the story told by the patient. It is then time to begin the third phase of ego-structuring.

The purpose of the third phase of ego-structuring is to deal with the transference so that the ending of the therapy does not leave a wound in the patient. By the transference, the patient projects the power of knowledge onto the therapist. The therapist is, in Lacan's terminology, the "subject supposed to know" (Lacan 1981b, Seminar XI, Ch. 18; Fink 1997, 29). That power of knowledge projected onto the therapist during the therapy process must now be returned to the patient. The patient is asked to select a date, a month or two from the current date, which will be the last session. The patient, him or herself, is thereby asked to choose the date of the end of the therapy. The patient is delegated the power to make the decision about the end date. The patient might in return request to diminish the amount of sessions pro week. The therapist should accept such a demand (Villemoes 2002, 655).

The method of transferring back the power that the patient projected onto the therapist requires from the therapist that he master his or her own narcissism. The therapist needs to say to questions of the patient that he does not know much about the topic of the question. The therapist must show his or her own lack to the patient. When the last day of therapy comes the patient cheerfully and lightheartedly consults his watch and says something like: "Well, this was the last time, good-bye" (Villemoes 2002, 655). The therapist, on the contrary "feels at a loss, rejected and miserable" until the therapist realizes that the cheerfulness of the patient and his or her own sadness is the sign of a successful termination of the therapy (Villemoes 2002, 655).

Conclusion

In this paper I have argued that severe mental illness, like schizophrenia, is not just a genetic illness. This theoretical claim is statistically proven by the studies of Tienari. I have used Lacan's theories to demonstrate that schizophrenia is explainable as a defective psycho-social and linguistic development. By appropriate therapy methods that deficit can be remedied. The results of the "Open Dialogue" method in Finland give statistical proof that more than 80% of persons afflicted by schizophrenia can be completely cured so that they can resume their studies or their work.

In this paper I have concentrated on one method to treat persons afflicted by schizophrenia: the Ego-structuring method developed by Palle Villemoes. The ego-structuring method avoids antagonizing the schizophrenic patient even in the way the sitting arrangement is done. The main aim of the ego-structuring method is to increase the patient's relation to language. This is done by helping the patent describe objects, first in the consultation room, then in the patient's own environment and then in the patient's memory starting from his earliest memory until now.

In describing objects, the patient reveals the relations (s)he developed over his/her life time. He or she thereby constructs his/her life-story. This life story then performs the function of the missing third in the psychic structure of the psychotic patient. The experience of sadness towards the end of the therapy indicates that the patience is able to experience a loss connected with the transition of ideal-ego (I am, as baby, everything to my mother) to an ideal-ego where I have to choose between wanting to become a doctor, a lawyer or a teacher but not all three together. Villemoes considers this experience of loss equivalent to the loss experienced in the Oedipus complex.

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