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# *Accompanied Autoanalysis: An Empathic Approach to Helping Deeply Disturbed Persons**

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Through accompanied autoanalysis, people can become experts regarding their own minds and thus arrange the lifestyle that suits them. In this process empathy becomes one of the most powerful assets we have to help others help themselves. Nevertheless we must not forget that empathy has its limits, given the immense personal capacity and interest required to know someone intimately. People have to do that for themselves. In the long run, everyone depends on what I would call "autoempathy." Much has been said about the power of empathy in relation to others, but the importance of "autoempathy" has been left aside.

We know that people usually "invent" others instead of discovering how others really are. But what is even more surprising is that people also "invent" themselves while they nonetheless often refuse to become experts on themselves. As we shall see, accompanied autoanalysis illustrates the importance of empathy, insofar as it allows others to be themselves, no matter why they are the way they are.

If we accept that empathy is the power to understand and imaginatively enter into another person's feelings, then we also realize that not being empathic influences the depth of our understanding of the other person. Lack of empathy toward so-called psychiatric patients has contributed to much of the abuse that sometimes goes on under the name of therapy. In

*Previously appeared in *Ethical Human Sciences and Services: An International Journal of Critical Inquiry*, Volume 2, Number 1, Spring 2000. Springer Publishing Company, NY.

this sense, being empathic makes it difficult for therapists acting in good faith to harm their patients. Similarly, self-hate and self-destructive practices grow from lack of empathy for oneself.

## BACKGROUND TO THE PRACTICE OF ACCOMPANIED AUTOANALYSIS

FUNGRATA is an institution dedicated to the rehabilitation of homeless, so-called psychotics. Working since 1976 in private practice and at Fungrata (Fergusson, 1986) since 1982 with at least 500 persons diagnosed as schizophrenics,[1] has allowed me to develop the approach I now call accompanied autoanalysis.

Although initially accompanied autoanalysis was publicly described mainly with so-called psychotic people, it has always been used in all sorts of mental states, including the rehabilitation process of so-called physical patients. It is in fact often referred to as Accompanied Autorehabilitation.

*Recognizing my failures* was the first and most important factor in developing accompanied autoanalysis. The fact that I repeatedly failed to achieve my objectives led me to adopt a humble scientific attitude that both invited and allowed me to look for new approaches. It also led me to a *profound awareness of my ignorance.* I accepted, not without pain, that I ignored how the brain really functions, that I had no idea what schizophrenia really was, if indeed it was an identifiable condition. Scientific knowledge was far from sufficient to justify the types of treatment I was using.

I therefore decided *to hand over the responsibility of the treatment to my patients.* It was as if I had said to them: "Look my friend, I am very sorry. I have done my best but I have failed. I don't know what should be done. You now have to assume full responsibility for yourself and your treatment. The most I can do is to be by your side while you work on yourself." This was the origin of the two key words: Autoanalysis (you do the work) and Accompanied (I shall be close to you). Self-reliance and autonomy on the part of the patient—rather than authority, coercion, and dependence—seemed to be the only way forward.

I observed that *mental health professionals usually try to maintain a monopoly on scientific knowledge.* Therefore, if patients were going to be responsible for their own rehabilitation process, it seemed obvious that I should share with them all available knowledge about the mind and the brain, as well as my own ignorance about these matters.

As a consequence of the information I provided, plus the self-knowledge they acquired while I accompanied them, my clients spontaneously began

to consider making all sorts of *changes in their everyday lifestyles.* Creatively, they began to find new ways to live their lives so that their risk of becoming psychotic diminished. All I did was to encourage their creativity and accompany them during the process.

At the same time, I began to seriously consider the popular myth according to which mental health professionals are mad themselves. If there is an element of truth in this myth, then becoming a mental health professional would constitute some sort of autotherapy. I realized that becoming a mental health professional means basically that you can have access to knowledge and information about the mind and the brain. If having that knowledge improves the prognosis of some of those professionals—in my view because it happens to help one design one's life—everyone could benefit from having that knowledge without having to become a mental health professional.

Eventually I accepted that, at least in theory, most clients could live with few or even no further psychotic breakdowns, if they became experts on themselves and found the lifestyle that suited them. People have the right to try to seek that lifestyle as often as they can and wish. In practice, most therapies (biological, psychological, or social) offer few such opportunities.

Harding and Zahnister (1994) demonstrated that "once a schizophrenic always a schizophrenic" is a false idea. I have observed that it can sometimes take 10 or 20 years for a schizophrenic state to disappear. Most often the healing occurs in spite of therapy. The least we can do is to try not to impede natural healing forces.

According to our current scientific knowledge, schizophrenic states cannot be confidently considered illnesses. However, we do know that being diagnosed schizophrenic has complicated social, psychological, and biological consequences. The latter flow from the coercion, repression and, we have to admit it, sometimes even torture-like procedures that some use under the generic label of "treatment." Being diagnosed as schizophrenic in itself causes a peculiar kind of illness, or at least a very severe trauma, that has to be dealt with.

As Robbins (1997) pointed out, "I have repeatedly discovered that persons who pass as experts on the treatment of schizophrenia have never or almost never actually involved themselves in intensive and protracted relationships with individual schizophrenic patients." This is mainly due to the high emotional cost that treating schizophrenic states has for the therapist. Therapists all too often end up being victims of the procedures they created. I therefore decided that accompanied autoanalysis should be friendly to the caregiver. One need not be masochistic to accompany people undergoing schizophrenic states. As far as possible, the whole process should be a pleasant and enriching experience for both parties.

I realized that society has been designed so that even in the best of cases only so-called normal people can satisfy their basic needs. People considered mentally or physically handicapped are in my view those who have difficulties with apparently simple, everyday tasks and situations that do not cause such stress to the majority of the population. Society still does not make enough effort to create a friendly environment for the so-called handicapped who usually have to do that for themselves. People who suffer from schizophrenic states are no exception to this rule.

I also entertain the hypothesis that there is an interdependence between lifestyle and some biochemical changes in the brain. Certain lifestyles can sometimes bring more favorable changes in the biochemical balance of the brain than those induced by medication, with far fewer undesirable effects. Of course, we are ignorant of the details of those putative changes, but neither do we know the exact nature of the changes brought about by medication.

In my work I have tried to integrate scientific knowledge with the defense of the human rights and civil liberties of those labeled as mentally ill. Although science and human rights movements should work hand in hand, they often fail to do so. That is why it is so important to seriously attempt to take a critical look at some of the conclusions of official scientific literature. The recent work of Breggin (1991, 1997) constitutes a useful contribution in that direction.

## Basic Hypotheses of Accompanied Autoanalysis

The basic hypothesis is that most schizophrenic states occur when people with a predisposition to those states (Cullberg, 1998) force themselves to live according to certain standards that do not suit them. However, most of these people can find an individual and peculiar lifestyle that suits their inner mental world and diminishes their risk of entering a psychotic state. They can discover such a lifestyle if they become real experts about themselves and assume full responsibility for organizing their lives. Through accompanied autoanalysis people can become experts on themselves and seek the lifestyle they need. If they persist they can try again and again until they finally succeed.

Unfortunately most current therapies work in the wrong direction, impeding real self-knowledge and creative encounters with new lifestyles. Most therapies convey a strong and wrong message that therapy will bring about desirable change. In reality, the outcome of schizophrenic states is to a large extent dependent on the amount of self-commitment. Only those who accept that the current status of scientific knowledge and mental health

expertise is very limited, and that they have to find the way by themselves, really have a chance to reach their objectives. It is desirable to try and overcome any dependence on biological, psychological or social therapy. That is why I speak of "Autoanalysis," and propose that the best and most effective way to try to help is to "Accompany" those who are working on their Autoanalysis.

## THE PROCESS OF ACCOMPANIED AUTOANALYSIS

Accompanied autoanalysis was arrived at gradually, through trial and error. Suggestions given by the Accompanied Persons as well as the theoretical considerations about schizophrenic states were most useful in the process. I have been able to use accompanied autoanalysis in its complete structure mainly in my private practice. I am gradually finding ways to use it with low-income people and especially with homeless people at Fungrata. I have observed that genuine scientific knowledge about one's own mind, no matter how limited it is, has in itself a healing and humanizing power, probably because it is never absolute and has a dynamic and collective character. This may be why it tends to generate change and psychological growth.

By scientific knowledge about one's own mind I do not mean the knowledge that you can find in scientific literature. I mean scientific knowledge about the everyday functioning of one's own mind. Unfortunately, the viewpoint provided by the mental health establishment very often contains pseudoscientific conclusions. Therefore the Accompanied Person must have tools to enable him to distinguish between pseudoscientific and scientific knowledge.

The process of accompanied autoanalysis can be divided into three main phases: Preparatory, Intensive, and Permanent.

### Preparatory Phase

During this phase the Accompanied Person's basic goal is to become, as far as possible, an expert on what is known about the mind in general and on their own minds. During this phase the Accompanied Person learns about psychotic states, schizophrenic states, and general psychopathology. That knowledge must include clinical experience, in the sense that those who receive it must have been in touch with people suffering from a variety of psychological conditions. Accompanied Persons learn how to elaborate a good biography and clinical history, so that they can prepare their own. Our model of clinical history includes different levels of functioning and

psychosocial aspects (Fergusson, 1994). The self-knowledge obtained through accompanied autoanalysis differs from insights usually obtained in long-term psychotherapy or psychoanalysis. During this and all other phases, accompanied autoanalysis may or may not replace other psychotherapies. The Accompanied Person has to become well aware of all the details and theoretical foundations of accompanied autoanalysis.

### Intensive Phase

The Accompanied Person can initiate the "intensive" phase at a time that is agreed upon with the Accompanying Person. The basic goal of this phase is to design a new flexible way of life. Throughout the whole of accompanied autoanalysis it is assumed that scientific knowledge about the mind in general, and especially about one's own mind, tends to generate changes in one's lifestyle.

Most lifestyle changes consciously or unconsciously aim at avoiding what I term Psychological Damage, Destruction, and Decomposition. This concept emphasizes that mental life is part of the material (biological) world and as such is subject to all the vicissitudes of living things. We tend to forget that mental life can be damaged or destroyed and might decompose. We realize that we can break another person's bones, but we tend to forget that people can literally, not only metaphorically, destroy parts of another person's mental life.

The Accompanied and Accompanying Persons must commit themselves to the intensive phase, making it a priority in their daily life. Accompanied Persons must be in a social, psychological, and economic position that allows them to persist in this phase for as long as they wish to do so. For example, they must be able to choose how and where they are going to live, according to their realistic wishes, and using common sense.

During this phase the Accompanying and the Accompanied Persons should meet at least twice a week. The latter should determine the duration of each meeting as far as possible. Taking obvious human limitations into account, meetings might be 10 minutes or 6 hours long. The Accompanying Persons must try to organize their time in order to satisfy such needs.

Besides planned meetings, Accompanying Persons must be available by phone and/or by e-mail. Video conferences through the Internet can also be useful. The Accompanying Persons' basic task is to listen and express occasional insights to the Accompanied Persons, who do the essential work. At the end of the intensive phase, Accompanied Persons have designed and started to put into practice a new, realistic, and flexible lifestyle according to their acquired knowledge.

### Permanent Phase

During this phase the participants maintain and improve what has been practiced and learned throughout the preparatory and intensive phases. They must meet at least once every 3 months, and, if possible, whenever the Accompanied Person wishes. At least twice a year, for at least 15 days, the intensive phase must be repeated as described above. Flexibility in the lifestyle and in any emotional or working activity in which the person is involved must be maintained. A system to obtain new scientific information must be established. As examples, a subscription to a journal and attending conferences can be useful.

## GENERAL CONSIDERATIONS ABOUT ACCOMPANIED AUTOANALYSIS

Becoming an expert on one's own mind and redesigning one's life in a creative manner in accordance to such knowledge constitutes accompanied autoanalysis' main objective. By that I mean that people become experts in *how they are.*

The hypotheses people make about *why they are* the way they are, tend to remain speculative. The "why" becomes important in developing a sense of freedom—knowing and taking into account inexorable social, psychological, and biological laws. In this sense, to be free is not to do what one wishes. It is rather to know "why" you wish what you wish. Thanks to knowledge of the "whys" human alienation is diminished and a more complete biological, psychological, and social human being can begin to develop.

Accompanied autoanalysis promotes the civil liberties and rights of people diagnosed with schizophrenic states, thereby integrating the political with the scientific. The traditional dichotomy between politics and science has been negative for both of them. Instead we must find ways to relate to those people without violating their basic liberties and rights. Accompanied autoanalysis is an attempt in that direction.

Accompanied autoanalysis tries to promote changes in the attitude toward "mental illness." What other authors have called the subjective experience of schizophrenics (Strauss, 1989; Jenkins, 1991) changes with accompanied autoanalysis. The Accompanied and Accompanying Persons' ambivalence toward mental illness often changes, especially in regard to the attitude toward so-called crises. The word crisis has been more or less synonymous with failure, and is therefore feared by patients, therapists, and

the public in general. Fear of so-called madness and its crises are among the main reasons why mad people are discriminated against.

Accompanying Persons must be able to create an atmosphere that will help all participants to enjoy the whole process no matter how hard it is. A great deal of enthusiasm has to be transmitted to the Accompanied Persons so that they become optimistic about the possibility of becoming experts on their own minds and redesigning their own lives. Sense of humor should be used whenever possible.

### Respecting Choice

Accompanying persons must allow Accompanied Persons to be creative and ingenious. They must view *changing and/or not changing* as equally important and feasible possibilities for the Accompanied Persons to choose. Accompanying Persons must not be overly moralistic, and it is desirable that they realize that no one seriously and scientifically knows what others should do with their lives. Sometimes the only way people are able to avoid madness is to live in a so-called mad way.

## A BRIEF CASE ILLUSTRATION

JB is 35 years old. From the age of 20 until the age of 29, he went through a "typical" psychiatric illness and treatment. He was diagnosed as paranoid schizophrenic, hospitalized four times and prescribed many "antipsychotic" drugs. For 4 years he underwent psychoanalysis (with a Winnicott-oriented analyst) and he also received 2 years of psychoanalytically-oriented psychotherapy and 10 months of systemic and cognitive-oriented therapy.

After a crisis, he had to leave the university where he was studying industrial engineering. He tried several low-key jobs, but was fired each time a crisis occurred. He married, had one daughter, and divorced after only 12 months. In classical psychiatric terms, he presented incoherence and derailment in his speech, delusions, hallucinations, disorganized behavior, affective flattening, and mood swings. His symptoms were persistent and increased from time to time.

I first saw him when he was 29 years old. I explained accompanied autoanalysis to him and for 13 months we worked in the preparatory phase. He studied texts on psychiatry, psychology, and psychoanalysis; reviewed different psychological schools of thought; and used the Internet to obtain information. He attended conferences and lectures on biological psychiatry, psychology, and psychoanalysis, sometimes concealing his real identity in

order to be admitted. He reviewed different theories about the etiology of schizophrenia (genetic, biochemical, infectious, psychological, social, and so on), and read conventional antipsychiatric literature. While studying, he gradually elaborated on his own clinical history and autobiography.

During the preparatory phase he once entered into a severe crisis that was nevertheless dealt with at home. He began to reduce medication but he had to increase it again, mainly because at that time we were not as aware of the withdrawal symptoms that vary enormously in each individual.

He identified many things that triggered his crises and began to recognize ways to handle them. For example, he realized that if he spent the whole night holding someone's hand, with the light on, and with the possibility of contacting the Accompanying person on the phone, he could handle the crisis. Nevertheless, although he suffered less and felt positive about himself, all the symptoms persisted during the entire preparatory phase. As far as his personal knowledge was concerned, he identified his resentments, the typical provocative situations that stressed him and his most intense guilt feelings. He also began to identify the adequate intensity for his interpersonal relationships.

By resentment I mean a process through which people renounce their original wishes because they feel they would not be able to gratify them and instead develop false wishes. Thereafter, any gratification they obtain will necessarily be false and they will never forgive the false gratifying object because it is not the originally desired one. It is only with great psychological pain that people manage to recapture their original wishes and goals, yet real wishes and goals are the best way to reverse previous Psychological Damage, Destruction, and Decomposition.

By provocative situations I mean those that make people do what they do not want to do. Accompanied Persons have to become real experts in detecting situations that provoke them. Reactions to provocative acts constitute the main cause of Psychological Damage, Destruction, and Decomposition.

In general those who have schizophrenic states must learn to avoid provocative situations. It is not sufficient to have self-knowledge if one doesn't adjust one's lifestyle accordingly. It was not until he entered a 4-month intensive phase and began to change his lifestyle that some of JB's symptoms began to disappear. All his changes were related to his newly acquired knowledge. Most were very simple ones, and they corresponded to everyday life choices. He changed the place were he lived and with whom he lived. He modified his sexual habits and changed his type of friends. He developed new ways of relating and, for example, realized that he had to live with a dog and to sleep close to it.

He got in the habit of calling me, sometimes with great enthusiasm, when a crisis was beginning, so that we might discuss the details of it. He learned to welcome crises.

He realized that he felt better with older women and men. He decided never again to visit people who could damage him. He decided that he should develop new friendships, so that he would not have to interact with those who had already labeled him as a mentally ill person, and so on. Before he underwent accompanied autoanalysis, JB had concentrated his efforts on understanding *why* he was like he was, instead of learning in the greatest detail possible *how* he was.

During accompanied autoanalysis, people try to arrange their life according to the way they are, independently from the motives that led them to be like that. This does not mean that they cannot try to find out why it is that they are how they are. They can do that, and while doing it they might change or they might not. *Nevertheless, merely understanding without changing is a luxury that people suffering from schizophrenic states cannot afford. The consequences are severe psychological Damage, Destruction, and/or Decomposition.*

JB has been in his Permanent Phase for the last 5 years. He has been medication-free for the past 2 years. He has repeated the Intensive phase twice a year.

## Psychosis as Psychological Damage, Destruction, and Decomposition

Observation has led me to propose that, psychologically speaking, psychotic states are equivalent to Psychological Damage, Destruction, and Decomposition. This suggests that psychotic states as such are "leftovers." For instance, all the symptoms of schizophrenic states are largely evidence of psychological remains and detritus. Those states occur when the "real being" and the "psychological life" of the human being cannot and do not prevail.

Psychotic symptoms often have no special meaning. They are not defenses. They are what is left of what once was the original "real being" of "psychological life." The question is not really why some people become delusional or what it means to be incoherent. The question is: What is the "psychological life" that is being damaged or destroyed, or is already decomposing?

This process is similar to what happens to the body of a human being after biological death. Continuing processes take place in the body, even though it is dead. While in a psychotic state, humans are *not being.* We have spent too much energy on understanding what psychotic states are and very little on what they are not.

By my definition, psychological damage is always reversible and psychological destruction and decomposition are irreversible. Nevertheless, in practice hope cannot be lost, and in fact, many surprises are encountered. Sometimes psychological material is, so to speak, buried alive. In schizophrenic states, what is at stake is a struggle between psychological life and psychological death.

## CONCLUSION

People with a predisposition to enter into schizophrenic states can take no chances with their lifestyle. If they do not adjust their lifestyle permanently, psychological damage and/or destruction and decomposition can occur and thus they can enter into a schizophrenic state. They have to become experts on how their own minds function and how to design a lifestyle according to that knowledge.

As I said at the beginning, no one has the capacity or the interest to know someone else in the degree of detail that is required for this endeavor. People must do that for themselves. Accompanied autoanalysis seeks self-reliance and autonomy.

## NOTE

1. Together with other authors such as Thomas Szasz (1961, 1978), I have serious doubts with regard to the validity of words and concepts such as therapist, patient, mental illness, mental health, psychotherapy, psychiatrist, schizophrenia, madness, psychosis, and so on. The reader must always assume a "so-called" before those words whenever they appear in this article. Nevertheless they are used because it is otherwise difficult to ensure that we are all referring to the same thing. As far as schizophrenia is concerned, I prefer to speak of *schizophrenic states.*

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# Dimensions of Empathic Therapy

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2002