Is Chronicity a Function of the Relationship Between the Person and the Auditory Hallucination?

by Lorna Smith Benjamin

Abstract

Thirty psychiatric inpatients each rated their relationship with their auditory hallucination using the Structural Analysis of Social Behavior questionnaires which assess partnerships in terms of interpersonal focus, love-hate, and enmeshment-differentiation. Results showed that all subjects had integrated, interpersonally coherent relationships with their voice. Qualitative differences in the nature of the relationships related meaningfully to diagnosis. Selected clinical excerpts suggested that the relationship with the hallucination may serve an adaptive function. Chronicity may be dependent on the nature of that adaptation.

Schizophrenic thought disorder is now believed by many to be the result of a genetically based excess of neurotransmitters. Modern psychiatry has provided welcome psychological relief to parents of schizophrenic patients who had in recent decades felt blamed and held responsible for the schizophrenia. Dynamically oriented clinicians had insisted that family interactions have a lot to do with the appearance and the maintenance of the illness.

Thanks to neuroleptics and to the recent successful community-based mental treatments (Stein and Test 1980), many people with schizophrenia are no longer held in “back wards,” and often are released from hospitals to live in a semi-independent status within the community. Nonetheless, schizophrenia still is viewed as a chronic disease, and its victims remain vulnerable to relapses, and how to help people with schizophrenia better maintain self-care. For example, data suggest that psychoeducational family therapy, conducted with the purpose of helping families cope with the biochemically induced deficiencies inherent in schizophrenia, can delay if not avoid relapse. In these therapies, the therapists engage in the following activities:

... an empathic nonblaming alliance; psychoeducation about schizophrenia and its management; identification of prodromal signs of relapse for targeting drug interventions; training in changing maladaptive interaction patterns such as expressed emotion, negative affective style, communication deviance; reducing stigmatization; and expanding social networks. [McGlashan 1986, p. 107]

Recently completed long-term followup studies have challenged the prevalent clinical belief that schizophrenia is fundamentally a chronic disease with an inevitable downward progression (Harding et al. 1987). Surely the better news partly reflects better treatment methods, but in addition, questions have been raised about whether the clinical belief about the intractability of schizophrenia was wrong in the first place. It is not hard for the practitioner to cite cases that certainly “looked” schizophrenic, but because they got better, subsequently were thought not to have been cases of schizophrenia.

Challenge to the idea that schizophrenia is necessarily chronic is not new: Sullivan (1929/1953)
reproached colleagues for their devotion to a "medical model" and insisted schizophrenia was a human process, having much to do with social interactions. If their problems were treated in social terms, Sullivan believed people with schizophrenia could recover, or at least avoid the massive deterioration so often observed.

It is both frustrating and tragic that such discussions of social factors often are reduced to a quest for placing blame. Wynne (1983) has provided an enlightened discussion of shifts in blame among evil spirits, patients, families, dynamic theorists, and genes. One of the many costly consequences of such a "courtroom approach" within the scientific community (assign/resist/reassign blame/punishment) is that minds are closed, inquiry is constrained, and the possibilities for new understandings and any associated better interventions are greatly inhibited.

If the agenda of blame can be set aside, and the scientific process of logical positivism can be applied, new and useful knowledge may result. Clinical science is a process that usually includes at least three basic steps: (1) description and hypothesis construction, (2) operationalization of measures and empirical testing, and (3) clinical application of results. According to this algorithm, scientifically based psychosocial hypotheses about schizophrenia must be formulated in terms of operations that can be repeated by any appropriately trained observer who, in turn, must obtain the same results and reach the same conclusions. To date, with respect to the question of treatments based on an understanding of the etiology of schizophrenia, the leap from hypothesis to clinical application has been made in both the psychosocial and the biochemical realms without adequate completion of the essential middle step. Operationalization and empirical testing of the respective hypotheses have been largely neglected and, as a consequence, scientific theory building, testing, and refinement have been retarded.

Although they have recently fallen into disrepute in mainstream psychiatry, clinical observations suggestive of a role for the family in the etiology and treatment of schizophrenia (Sullivan 1929/1953; Bateson et al. 1956; Wynne et al. 1958) remain viable as heuristic formulations. These independently generated clinical observations suggest that at least initially in the disease process, the illness, like the swelling of lymph nodes as a corrective response to a threatening infection, represents an attempt at adaptation. Once the psychotic process has started as a response to a noxious social invasion, as the sorcerer's apprentice learned, the magic gets out of control, the patient becomes overwhelmed and trapped, and, as Estroff (1981) so thoroughly demonstrates, the "normal" world steadily reinforces the "crazy" position. In other words, the patient's relationship with the illness is like the relationship of a damsel in distress to an evil rescuer. An attempt at a potential solution turns out to be as bad or worse than the initial problem.

The present hypothesis is that given a genetic basis for temperament, schizophrenic patients and their families have evolved a painful but understandable way of relating to themselves and each other. If the symptoms of schizophrenia are a consequence of an interface between social demands and an individual's own genetically set propensities for response, then, as Sullivan suggests, there should be a way to prevent or relieve at least some of the symptoms through education and other psychosocial interventions. Living with schizophrenia need not be a life sentence.

Beliefs about causality aside, Professors Strauss and Estroff suggested:

For the person with severe mental illness, the relationship with that illness is almost certainly a crucial contributor to chronicity or recovery ... It may, in fact, be just the difference between seeing oneself and the disorder as separate or becoming absorbed by it that is the crucial factor influencing the evolution of chronicity or recovery ... Can the person fight the illness ... [or] be overcome and destroyed [by it]? ... It is possible to suggest that meaningful interaction between person and illness takes place. It is essential that we overcome prematurely fixed beliefs, whether as "hard-nosed" scientists or militant humanists, to be able to explore these areas in a more creative, systematic, and careful way.

In specific response to the editors' initiation, the present article reports on the study of hallucinations by a highly operationalized, well-validated measure of social interactions and their internalizations. Responses of hospitalized psychiatric inpatients were analyzed using a computer algorithm. In other words, the data to be presented are totally replicable by any investigator having access to hallucinating subjects who agree to repeat the protocol. The method offers an operationalized description and associated empirical data on the social manifestations of auditory hallucinations.

It seems likely that the patient's
relationship with the hallucination reflects directly the relationship with the illness itself. Voices usually are directly related to the key symptoms of the psychotic illness, because the patient's responses correspond in meaningful ways to what the voice is saying. If the voice attacks the patient, he or she is depressed and suicidal. If the voice tells the patient to kill others, then, if the patient loses self-control, murderous attacks on others are likely. If the voice tells the person he or she is wonderful and powerful, grandiose manic behaviors appear. The patient's responses to the voice often are key factors in the decision to hospitalized. In other words, the content of the hallucination is directly responsible for the salient and anomalous behaviors associated with schizophrenia. There is evidence that hallucinating psychotics with different symptoms and different diagnoses do have different relationships with their hallucinations (Solovay et al. 1987).

Not only do hallucinations differ by diagnosis, but they also may differ within diagnosis according to the state of the illness; for example, Larkin (1979) reported that hallucinatory content in schizophrenia was "threatening and isolating" in the acute phase and "socially focused" during remission.

Theorists who favor a purely biochemical view of schizophrenia might argue that the illness determines the content of the hallucination. In other words, biochemically caused neural errors might conjure the images and thoughts of the hallucination. These competing hypotheses could be tested in an ideal longitudinal study by assessing interactional patterns in families and observing whether specific patterns precede and correspond meaningfully to the interactional patterns manifest in the hallucination. If given a well-validated, reliable, and sensitive measure of interactional patterns in families and in hallucinations, and if this measure showed no orderly relation between family patterns and patterns of hallucinations, then the idea that biochemistry causes the hallucinations independently of family milieu would be compelling. On the other hand, if there were sequential data showing that social patterns in the family precede comparable social patterns in the hallucination, investigators might be encouraged to look more carefully at the possibility of changing family interactional patterns as a way of preventing and/or ameliorating schizophrenia. Since no such studies have been completed, the point at the moment is only that the content of the hallucination and the patient's response to it provide a reasonable measure of the patient's relationship with the illness. The present method of approach can open a way to study the patient's relationship with his or her illness, and the impact of that relationship upon chronicity. Ultimately the approach could apply to broader questions about psychosocial aspects of the etiology and function of the hallucinations in particular and of the schizophrenia in general.

Method of Measuring the Relationship With the Voice

The codification of the patient's relationship with illness is based on an "interpersonal microscope," a model of social interactions and associated internalizations called Structural Analysis of Social Behavior (SASB) (Benjamin 1974, 1984). The SASB model can be used clinically to operationalize and quantify crucial interactive patterns in schizophrenia. In Humphrey and Benjamin (1986), there is a specific proposal for application of the SASB model to the Bateson et al. (1956) description of the double bind and to the Wynne et al. (1958) description of pseudomutuality alleged to occur in families with a schizophrenic member. The SASB model stems from the interpersonal psychiatry of Sullivan (1929/1953), and has a long research heritage in interpersonal circumplex theory as outlined by Leary (1957), Schaefer (1965), and others. The SASB model, as well as its associated coding system, rating scales, and software, has been validated by a number of methods including factor analysis, autocorrelational techniques, dimensional ratings procedures, circumplex analyses, and correlations with criterion measures (Benjamin 1974, 1984, 1988).

The data discussed here were gathered in a 4-year-long study of 194 psychiatric inpatients rating a large battery of tests including the questionnaires based on the SASB model. In that study of social perceptions and psychiatric symptomatology, patients were carefully diagnosed using information gathered by the Diagnostic Interview Schedule (DIS; Robins et al. 1981) structured interview and by a scan of the chart using a formal checklist. These diagnostic data from patients' self-reports and from clinicians' observations were processed by a computer-driven DSM-III (American Psychiatric Association 1980) algorithm, with the hierarchical decisions guided by the Linking Interview With Diagnostic Rules (LIDR) manual (Greist et al. 1984). In general, results support the proposal that there are stas-
tically significant differences among diagnostic groups in perceptions of the interpersonal behavior of family members as measured by the SASB technology (Benjamin 1986). There was a subsample of 30 individuals who rated their auditory hallucinations, and these are the subjects of the present study.

The Intrex questionnaires (Benjamin 1984, 1988), which measure perceptions of other people (he/she/they) and the rater’s view of self in relation to those others (I), were also used to measure patients’ relationships with their auditory hallucination. Psychotic inpatients had little difficulty using the standard interpersonal format to rate their auditory hallucinations as if he or she or it were another “person.”

The SASB hypothesis is that social interactions and their internalizations can be described by just three dimensions: interpersonal focus, love-hate, and enmeshment-differentiation. These three dimensions are diagrammed in figure 1 and applied to the cluster version of the SASB model in figure 2. The meanings of figures 1 and 2 will be explained in conjunction with figure 3, which presents the ratings of auditory hallucinations made by two illustrative persons with paranoid schizophrenia, subject #176 and subject #213.

Items for the Long Form Intrex questionnaire, used in the present study, are presented in table 1. In the table the items are arranged by clusters shown in figure 2. Cluster names begin with 1, 2, or 3, depending on whether they appear on the top (1), middle (2), or bottom (3) part of figure 2. The second part of the cluster name ranges from 1 to 8 and depends on location, starting with number 1 at 12 o’clock and proceeding clockwise. For example, cluster 1–4, Nurturing and Protecting, is in the #1 group of items in figure 2 and table 1 (Transitive action group). Cluster 1–4 is the fourth cluster counting clockwise from cluster 1–1, which is at 12 o’clock. A subject’s score for cluster 1–4 was created by his or her endorsement of the four items listed in table 1 under cluster 1–4, Nurturing and Protecting.

Each item was rated on a scale ranging from 0 (the item does not ever apply at all) to 100 (the item applies always, perfectly). The items sampling each cluster in figure 2 were presented to the subjects in a randomly determined order, and then averaged to determine the cluster score for a given relationship. For example, the top part of figure 3 shows that subject #176 had a score of 100 for cluster 1–4 (the voice focuses), indicating that he assigned a score of 100 to each of the four items shown in table 1 as descriptive of cluster 1–4:

My voice lovingly looks after me and takes steps to protect me, actively backs me up.

With much kindness and good sense, my voice figures out and explains things to me.

My voice gets me interested and teaches me how to understand and do things.

My voice pays close attention to me so it can figure out all of my needs and take care of everything.

The fact that a hallucination can be experienced in such a loving and nurturant manner may be a surprise to some, but this finding is not unusual as will be shown in figures 4 and 5. Inspection of the items for cluster 1–5 in table 1 shows that a score of 100 for cluster 1–5 is consistent with the more typical understanding of a patient’s experience of his or her voice. One example: “Believing that [he or she] really knows what is best for me, my voice tells me exactly what to do, be, think.”

The dimensions shown in figure 1 guided the writing of the SASB questionnaire items. Each item has an exactly prescribed focus, and a specifically designated position on the love-hate dimension, as well as on the enmeshment-differentiation dimension. The three types of focus are shown from left to right by the stick figures at the top of figure 1: (1) transitive focus directed toward another; (2) intransitive reaction to another; (3) transitive focus directed inward upon the self.

Subject #176’s rating of all items in cluster 1–4 at 100 indicates that the voice was experienced as engaging in transitive focus upon him.

The second dimension in the SASB model written into the items in table 1 is the love-hate dimension, represented by the horizontal axis in figure 1. It ranges from maximal attack (-9) to extreme friendliness (+9). The items in cluster 1–4 are moderately friendly, ranging from about +3 to +6 on the horizontal scale. The endorsement of all cluster 1–4 items with the maximal rating 100 suggests that subject #176 experienced his voice as moderately friendly (+3 to +6 on the horizontal scale).

The third dimension in the SASB model is the enmeshment-differentiation dimension shown on the vertical scales of figure 1. The vertical scales differ for each type of focus: if the focus represents a transitive action, then the enmeshment is represented in the extreme by Control (-9), and differentiation is represented in the extreme by Give Autonomy (+9). If the focus is an intransitive state or reaction, then the vertical dimension runs from Submit (-9) to Be Separate (+9).
Figure 1. Dimensions of interpersonal space according to Structural Analysis of Social Behavior (SASB)

FOCUS: OTHER SELF INTROJECT

Transitive Action Intransitive State Action Inward

Hostile -9 -6 -3 0 3 6 9 Friendly

Give Autonomy Be Separate Let Self "Be"

Give Autonomy Be Separate Let Self "Be"

After defining interacting referents X and Y, X's position is coded in terms of focus represented by the three stick figures: Transitivity is coded if the emphasis is on what is happening to Y. Intransitivity is defined if the emphasis is on what is happening to X, and introjection is coded if the event is about what X is doing to himself or herself. The second judgment is of affiliation represented by the horizontal scale, and the third judgment is of interdependence shown on the vertical scales located under their respective types of focus. From: Benjamin, L.S., Adding social and intrapsychic descriptors to Axis I of DSM-III, in: Millon, T., and Klerman, G.L., eds. Contemporary Directions in Psychopathology. New York: The Guilford Press, 1986. pp. 599-638.

The items for cluster 1-4 in table 1 are influential in the range of about -3 to -6. Subject #176's endorsement of cluster 1-4 items suggests that he experienced his voice as influential in the amounts described by that cluster: -3 to -6 on the vertical scale.

The introjective surface will not be discussed further here, because it was not measured in this data set.

The three dimensional judgments that a transaction is transitive, moderately friendly, and moderately influencing can be combined to yield the code: 1-4 Nurturing and Protecting on figure 2. An example of such an event might be the patient's experience of having his hallucination tell him to be sure the door is locked because somebody is trying to get in.

In addition to the questionnaire measures of the patient's perception of social events, there is a formal coding procedure for application of the SASB model to clinical or family or intrapsychic events. For example, if the patient said to the clinician, "My voice warns me when danger is near," the same dimensional analysis used to write the SASB questionnaire items could be invoked. The statement would be coded as follows: the referent X is the Voice, and the referent Y is the Patient. The XY transaction is judged from the point of view of X, the Voice. First, one of the three types of focus shown at the top of figure 1 is selected, and in this example, the voice is transitive. Friendliness is rated on the horizontal scale in figure 1, and would be about +4 in this example. The third judgment uses the vertical scales shown in figure 1; since the action is transitive, the vertical dimension is judged on the scale ranging from Control to Give Autonomy. In the
The three judgments outlined by figure 1 are combined to select the categories shown here. Cluster names begin with a 1 if they are transitive, 2 if intransitive, and 3 if introjective. The second digit of the cluster ranges from 1–8, beginning at the cluster located at 12 o’clock and proceeding clockwise.

Figure 3. Two paranoid schizophrenic patients rated their auditory hallucination on the items in Table 1 which define the clusters in figure 2.

<table>
<thead>
<tr>
<th>Score (composite of 4-5 items)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>S #176 rates his auditory hallucination</td>
</tr>
<tr>
<td>It focuses</td>
</tr>
<tr>
<td>S #213 rates his auditory hallucination</td>
</tr>
<tr>
<td>It focuses</td>
</tr>
</tbody>
</table>

The relationship between subject #176 and his voice was friendly. For subject #213, the relationship with the voice was hostile.

Table 1. Long-form Intrex items used to measure the relationship of the patient (P) with the auditory hallucination or voice (V)

Transitive group (top part of figure 2)

Cluster 1–1: Freeing and Forgetting
127. V forgets all about P, their agreements, plans.
128. Without concern, V lets P do and be anything at all.
129. V peacefully leaves P completely on his or her own.
130. V leaves P free to do and be whatever P thinks is best.
131. Believing P does things well, V leaves P to do them his or her own way.

Cluster 1–2: Affirming and Understanding
132. V lets P speak freely and hears P even if they disagree.
133. V really hears P, acknowledges P’s views even when they disagree.
134. V clearly understands P and likes P even when they disagree.
135. V likes P and thinks P is fine just as P is.

Cluster 1–3: Loving and Approaching
136. V gently, lovingly strokes and soothes P without asking for anything in return.
137. Full of happy smiles, V lovingly greets P just as P is.
138. With gentle loving tenderness, V connects sexually if P seems to want it.
139. V warmly, cheerfully invites P to be in touch with V as often as P wants.
140. V provides for, nurtures, takes care of P.
Table 1. Long-form Intrex items used to measure the relationship of the patient (P) with the auditory hallucination or voice (V)—Continued

Transitive group (top part of figure 2)

Cluster 1–4: Nurturing and Protecting
143. V lovingly looks after P's interests and takes steps to protect P. V actively backs P up.
144. With much kindness and good sense, V figures out and explains things to P.
145. V gets P interested and teaches P how to understand and do things.
146. V pays close attention to P so V can figure out all of P's needs and take care of everything.

Cluster 1–5: Watching and Controlling
147. Believing it's really for P's own good, V checks often on P and reminds P of what should be done.
148. Believing he or she really knows what is best for P, V tells P exactly what to do, be, think.
149. V controls P in a matter-of-fact way. V has the habit of taking charge of everything.
150. V makes P follow his or her rules and ideas of what is right and proper.
151. V butt's in and takes over, blocks and restricts P.

Cluster 1–6: Belittling and Blaming
152. V puts P down, tells P his or her ways are wrong, and V's ways are better.
153. V accuses and blames P. V tries to get P to believe and say P is wrong.
155. V harshly punishes and tortures P, takes revenge.

Cluster 1–7: Attacking and Rejecting
156. V rips P off, tears, steals, grabs all he or she can from P.
157. V puts P down, tells P his or her ways are wrong, and V's ways are better.
158. V murders, kills, destroys, and leaves P as a useless heap.
159. V angrily leaves P out. V completely refuses to have anything to do with P.
160. V angrily leaves P to go without what P needs very much even when V easily could give it to P.

Cluster 1–8: Ignoring and Neglecting
161. Just when V is needed most, V abandons P, leaves P alone with trouble.
162. V ignores the facts and offers P unbelievable nonsense and craziness.
163. V neglects P, P's interests, needs.
164. V just doesn't notice or pay attention to P at all.

Intransitive group (middle part of figure 2)

Cluster 2–1: Asserting and Separating
216. V is straightforward, truthful and clear with P about V's own position.
217. V freely and openly talks with P about his or her innermost self.
218. V expresses himself or herself clearly in a warm and friendly way.
219. V is joyful, happy and very open with P.
Table 1. Long-form Intrex items used to measure the relationship of the patient (P) with the auditory hallucination or voice (V)—Continued

Intransitive group (middle part of figure 2)

Cluster 2–3: Joyfully Connecting
212. V relaxes, lets go, enjoys, feels wonderful about being with P.
211. V is very happy, playful, joyful, delighted to be with P.
210. V joyfully, lovingly, very happily responds to P sexually.
241. V warmly, happily stays around and keeps in touch with P.
242. V warmly, comfortably accepts P's help and caregiving.

Cluster 2–4: Trusting and Relying
243. V is trusting with P, V comfortably counts on P to come through when needed.
244. V willingly accepts, goes along with V's reasonable suggestions, ideas.
245. V learns from P, comfortably takes advice and guidance from P.
246. V trustingly depends on P to meet every need.

Cluster 2–5: Deferring and Submitting
247. V checks with P about every little thing because V cares so much about what P thinks.
248. V feels, thinks, does, becomes what he or she thinks P wants.
240. V gives in to P, yields and submits to P.
238. V mindlessly obeys P's rules, standards, ideas about how things should be done.
237. V trustingly depends on P to meet every need.

Cluster 2–6: Sulking and Scurrying
236. V caves in to P and does things P's own way, but V sulks and fumes about it.
235. To avoid P's disapproval, V bottles up his or her rage and resentment and does what P wants.
234. Full of doubts and tension, V sort of goes along with P's views anyway.
233. V whines, unhappily protests, tries to defend himself or herself from P.

Cluster 2–7: Protesting and Recoiling
232. V bitterly, hatefully, resentfully chooses to let P's needs and wants count more than his or her own.
231. V is very tense, shaky, wary, fearful with P.
230. In great pain and rage, V screams and shouts that P is destroying him or her.
221. Boiling over with rage and/or fear, V tries to escape, flee, or hide from P.
222. V furiously, angrily, hatefully refuses to accept P's offers to help out.

Cluster 2–8: Walling Off and Distancing
223. V bitterly, angrily detaches from P and doesn't ask for anything. V weeps alone about P.
224. V reacts to what P says or does in strange, unconnected, unrelated ways.
225. V walls him or herself off from P; doesn't hear, doesn't react.
226. V is too busy and alone with his or her "own thing" to be with P.

Note.—The hallucination (he, she, or it) was rated on all 72 items (presented in random order), and then the patient was rated on all 72 items. Data from the 144 items are grouped in four modes: 1 = The V focuses on me (transitive action); 2 = the V reacts to me (intransitive state); 3 = I focus on V; 4 = I react to V.

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The coefficient can range from +1 (most attacking) to -1 (most friendly, least attacking).

Inspection of the first graph of figure 3 shows that subject #176 gave relatively low ratings to clusters 6, 7, and 8, which describe hostile parts of interpersonal space (1-6 = Belittling and Blaming; 1-7 = Attacking and Rejecting; 1-8 = Ignoring and Neglecting). He gave high endorsements to items in the friendly and neutral clusters (1-2, 1-3, 1-4; 1-5, 1-1). This overall experience of friendliness from his voice was summarized by an ATK coefficient of -0.85, a number suggestive of much friendliness.

On the second graph of figure 3, ratings made by a second person with paranoid schizophrenia, subject #213, a:e presented. This person experienced his voice as very hostile, as shown by the large cluster scores for clusters 1-8 and 1-7 (It focuses). There were no endorsements at all of any of the friendly clusters. The ATK coefficient for this data set was 0.83, a number suggestive of consistent hostility.

The CON describes the degree to which the ratings are consistently oriented around the Control (or submission) pole of the model. High CON coefficients are obtained if ratings are high for clusters on figure 2 representing much enmeshment (5), with progressively lower ratings for clusters located in the direction of more autonomy (6, 4; 7-3; 8, 2; 1). Inspection of figure 3 shows that illustrative subject #176 gave high endorsements to some control clusters (4, 5) and lower endorsements to some autonomy clusters (8, 1). The CON pattern for the transitive action from this subject’s voice was 0.70, which is moderately large. In summary, subject #176’s hallucination was both friendly and controlling, but it was more friendly (-0.85) than controlling (0.70).

The CON pattern for the transitive actions of subject #213’s voice was -0.70, indicating it had a moderately strong tendency to give autonomy. This is reflected in figure 3 by the relatively high scores for the autonomous clusters 8 and 1, and the relatively low scores for the enmeshed clusters 4, 5, and 6. In summary, subject #213’s voice was hostile (0.83) and neglectful (-0.70)

The third pattern coefficient (CFL) describes the tendency to make contradictory endorsements. Because findings with this parameter were not remarkable, it is not discussed further here.

Results

In figure 4, the ATK pattern coefficients were used to arrange the 11 paranoid schizophrenic individuals by the degree of transitive hostility shown by the voice. Inspection of figure 4 shows that 6 of the 11 people with paranoid schizophrenia experienced their voice as engaged in friendly transitive actions (subject #135, 176, 45, 146, 52, and 44), but 4 (subject #174, 101, 213, and 211) experienced their hallucination as clearly attacking. Two (subject #147 and 79) did not have a definitively consistent experience with transitive hostility or friendliness. If the pattern coefficient is greater in absolute magnitude than 0.71, then there is 50 percent common variance between data and pattern theory (see Benjamin 1988). If it is greater than +0.81, Monte Carlo methods have shown that it would be found in a random data set no more than 5 percent of the time (Benjamin 1988).

It is important to note that psychotic inpatients were asked to rate their hallucination on these interpersonal items; there was no discussion with the patients as to whether the hallucination was an internalization or not. Patients were simply asked to rate how the items applied to their hallucination. The subjects were free to score any and all of the items zero, indicating that the interpersonal items never applied in any sense. The fact that the resulting data set showed a great degree of order indicates the relationship with the hallucination has an organized structure consistent with that found in ordinary social relationships.

Classification of interpersonal events in terms of the SASB model permits prediction according to several different principles (Benjamin 1974, 1984). Complementarity, an idea formally introduced to the circumplex research literature by Carson (1969), holds that certain interpersonal positions maximize, or “draw for” others. In the SASB model, complementarity between the two interpersonal surfaces (1 = transitive action focused upon another; 2 = intransitive reaction to another’s transitive action) is shown by clusters at the same position in interpersonal space. For example, cluster 2-4, Trusting and Relying, located at about 4 o’clock on the middle surface of figure 2, is the complement of cluster 1-4, Nurturing and Protecting.

Complementarity theory would predict that if the hallucination is experienced as Nurturing and Protective (high scores for items in cluster 1-4), then the schizophrenic person should trust it, and also give high ratings to the items in table 1 describing cluster 2-4. These include:

1 I trust my voice, comfortably count on it to come through when needed.
Figure 4. Pattern coefficients for the 11 paranoid schizophrenic patients rating their relationship with their auditory hallucination

All but one (subject #79) had a pattern coefficient $\geq$ criterion magnitude of 0.71 in at least one dimension; this shows the relationship with the voice has an integrated structure consistent with the Structural Analysis of Social Behavior model in figures 1 and 2. Seven subjects had friendly relations with their voice (Negative Attack coefficients), and five had hostile relations (+ Attack pattern or ATK). The left panel (My voice focuses on me) and right panel part (I react to my voice) describe complementary domains. Similarities in bar graphs shows that the relations not only conformed to interpersonal structure, but they also were complementary.

I willingly accept, go along with my V’s reasonable suggestions, ideas.

I learn from my V, comfortably take advice and guidance from it.

I trustingly depend on my V to meet my every need.

Complementarity theory also predicts that if the hallucination is experienced as controlling, cluster 1–5, then the patient will endorse items in its complementary cluster, 2–5, indicating that the rater Defers and Submits to the Voice.

Complementarity is shown in figures 4 and 5 by the similarity of the scores in the data sets that are supposed to be complementary according to SASB theory. One type of complementarity is graphed in figure 4: the voice focuses (first graph) and I react (second graph of the figure). The similarity in scores shown in dark bars is marked and remarkable; so too is the similarity between the hatched bars. It should be noted that these parallel trends emerged from a set of 144 SASB questionnaire items (72 for it/he/she and 72 for I) presented in a randomly determined order, with each rating being free to vary from 0 to 100 without reference to any other rating.

Figure 5 shows a second type of complementarity in this sample of 11 people with paranoid schizophrenia; the second type consists of ratings: I focus on my voice (first graph of figure 5) and it reacts (second graph of figure 5). Again, the parallels, especially in the love-hate dimension are noteworthy. Subjects who described a friendly focus on the voice (subject #135, 176, 45, 44, 146, 52, 44, 147) all reported that the voice reacted with friendly approach. Striking deviations from complementarity occurred for subject #79, 174, and 211, who indicated that their voice reacted in the “loving” direction despite the fact that each attacked his or her voice and who, as shown in figure 4, felt the voice was attacking too. For these subjects complementarity failed in that there was much fighting with the voice, but the voice was experienced as loving the patient anyway. It could be relevant to establish the degree to which this particular deviation from complementarity also existed within the family.

A formal between-subject test of complementarity within the group having paranoid schizophrenia correlates the pattern coefficients.
which theoretically are complementary. Within the sample of paranoid schizophrenic subjects, the $r$ between patterns for It focuses and I react were ATK = 0.911 and CON = 0.277, showing that within the group of paranoid schizophrenic subjects, most of the complementarity of type (1—figure 4) was on the love-hate (ATK) dimension. For the complementary of type (2—figure 5), I focus and it reacts, r’s were ATK = 0.797 and CON = 0.756. The voice matched the raters’ perceived ATK, and was seen as submissive to the rater’s control (CON) or as taking autonomy in response to the rater’s autonomy giving. Complementarity held in both dimensions when the patient was initiating and the voice was reacting.

The orderliness in the data set shows there is interpersonal "rhyme and reason" to the experience of the voice in paranoid schizophrenia. The hallucination does not come toward the patient with random, chaotic messages, and the patient’s response to the perception of the voice is “normal” in an interpersonal sense.

There are a number of other interesting dynamic observations that cannot be discussed in the present context. For example, the subjects who were most submissive to their hallucinations are those whose voices were the most hostile (right-hand side of figure 5). The editors have wondered if greater submissiveness to the illness (voice) might correlate with greater chronicity. No data on chronicity are available in the present set, so the question cannot be pursued here. A second interesting question is whether the voice of a specific paranoid schizophrenic person can have different “moods” or “personal-
The two groups having clearly hostile relationships with their voice are the people with borderline personality (n = 6) and those with major depression with psychotic features (n = 3). The average ATK patterns for the group profiles were 0.93 and 0.84 (top and bottom parts of column 1 of figure 6, respectively) for people with borderline personality and 0.95 and 0.76 for the people who had major depression with psychotic features.

The diagnostic groups having clearly friendly relationships with their voice were the bipolar manic (n = 1) and the "other" group (n = 2) shown in the center of figure 6. ATK patterns for these group profiles were -0.82, -0.93 for "other" diagnoses and -0.83 and -0.86 for the bipolar manic group.

The mixed and indeterminate group profiles characterized all three schizophrenic groups in the sample: chronic undifferentiated schizophrenia (n = 3), paranoid schizophrenia (n = 11), and schizoaffective disorder (n = 4). As a group, paranoid people tended to have friendly relationships with their voices and to be autonomous as shown by the group profile coefficients for ATK (-0.29 and -0.85) and CON (0.32 and -0.47).

The schizoaffective group gave relatively high endorsements to the hostile items describing the voice, so the ATK patterns for the group profile were 0.80 and 0.31; like that of the paranoid people, the schizoaffective group profile suggests the voice was controlling and the patients reacted in the autonomous direction; CON = 0.41, -0.53.

The group with undifferentiated schizophrenia had a profile suggestive of much hostile control from the voice (ATK = 0.87, CON = 0.80), to which they reacted in the friendly and submissive direction (ATK = -0.29; CON = 0.47).

Comparison of the individual patterns for people with paranoid
schizophrenia shown in figure 4 with the group profile shown in figure 6 illustrates a long-discussed, still unresolved problem with using group profiles to characterize a data set. Figure 4 shows that the paranoid group contained seven subjects who had friendly relations with their voice and five subjects who did not. The group average shown in figure 6 was in the friendly direction, but the magnitude of the pattern (-0.29) was trivial. In other words, the group profile was not distinctive, yet the individual profiles were each distinctive, and in opposing directions. For the paranoid schizophrenic subjects, conclusions based on the group profile may misrepresent the experience of individuals. If the group profiles are not representative, then the data set must be interpreted in terms of individual findings.

The direction of differences in pattern coefficients at the individual level was tested by a $\chi^2$ test, and found to be significant in two modes for the ATK pattern, my voice focuses on me and I focus on voice. Results are presented for people with borderline personality disorder (BD). In figure 7. Inspection of figure 7 shows that each of the six people in this group had an extremely attacking and quite controlling experience of the voice (ATK and CON in the first part of figure 7) and responded to the voice with hostile protest (ATK in the second graph). Each person actively attacked the hallucination (ATK in the third graph of figure 7), and each person felt that the voice was utterly autonomous, not subject to the rater's influence (negative CON pattern in the fourth graph in figure 7). Because each individual showed a profile similar to that of the group (figure 6), the group profile is representative of individuals with borderline personality.

The quality of relationship with the hallucination is summarized for all individuals in table 2. Most had ATK and/or CON pattern coefficients of 0.71 or more, indicating at least 50 percent of the variance is shared by data and theory in most of the four modes (mode 1 = voice focuses on me; 2 = voice reacts to me; 3 = I focus on voice; 4 = I react to voice; complementary sets are 1:4 and 3:2). A scan of the table shows that except for paranoid schizophrenia who had hostile voices felt that their voices nonetheless liked them. People with undifferentiated schizophrenia were distinctive in that all had hostile voices and all were friendly in their transitive initiations toward that hostile voice (mode 3). No consistent trends for people with schizoaffective disorder are suggested by the data in table 2. Inspection of their pattern coefficients shows that they, like all others, had organized relationships with their voice, but each individual was unlike any other.

A formal test of complementarity

<table>
<thead>
<tr>
<th>Mode</th>
<th>Voice focuses $\chi^2$ (P = 0.033)</th>
<th>I react $\chi^2$ (P = 0.070)</th>
<th>I focus $\chi^2$ (P = 0.015)</th>
<th>Voice reacts $\chi^2$ (P = 0.075)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$-$ +</td>
<td>$-$ +</td>
<td>$-$ +</td>
<td>$-$ +</td>
</tr>
<tr>
<td>Psychotic depression</td>
<td>0 3</td>
<td>1 2</td>
<td>1 2</td>
<td>3 0</td>
</tr>
<tr>
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<td>0 6</td>
<td>0 6</td>
<td>0 6</td>
<td>2 4</td>
</tr>
<tr>
<td>Paranoid schizophrenia</td>
<td>7 4</td>
<td>8 3</td>
<td>7 4</td>
<td>10 1</td>
</tr>
<tr>
<td>Undifferentiated schizophrenia</td>
<td>0 3</td>
<td>2 1</td>
<td>3 0</td>
<td>2 1</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>1 3</td>
<td>1 3</td>
<td>1 3</td>
<td>2 2</td>
</tr>
<tr>
<td>Other</td>
<td>2 1</td>
<td>2 1</td>
<td>3 0</td>
<td>3 0</td>
</tr>
</tbody>
</table>

Note: A negative attack pattern indicates a friendly relationship, and a positive attack pattern indicates a hostile relationship. The $\chi^2$ test suggests that the quality of relationship with the hallucination was different for the diagnostic groups in at least two modes: 1 = my voice focuses on me, and 3 = I focus on my voice.
Figure 7. Pattern coefficients describing relationships with the voice in people with borderline personality

Voices of borderline personality
My voice focuses on me

<table>
<thead>
<tr>
<th>Case</th>
<th>92</th>
<th>40</th>
<th>136</th>
<th>182</th>
<th>144</th>
<th>184</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attack</td>
<td>1.00</td>
<td>0.75</td>
<td>0.50</td>
<td>0.25</td>
<td>0.00</td>
<td>-0.25</td>
</tr>
<tr>
<td>Control</td>
<td>0.87</td>
<td>0.63</td>
<td>0.39</td>
<td>0.15</td>
<td>0.00</td>
<td>-0.15</td>
</tr>
</tbody>
</table>

Voices of borderline personality
I focus on my voice

<table>
<thead>
<tr>
<th>Case</th>
<th>92</th>
<th>40</th>
<th>136</th>
<th>182</th>
<th>144</th>
<th>184</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attack</td>
<td>0.92</td>
<td>0.69</td>
<td>0.46</td>
<td>0.23</td>
<td>0.00</td>
<td>-0.07</td>
</tr>
<tr>
<td>Control</td>
<td>0.75</td>
<td>0.52</td>
<td>0.29</td>
<td>0.06</td>
<td>0.00</td>
<td>-0.06</td>
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</tbody>
</table>

Voices of borderline personality
I react to my voice

<table>
<thead>
<tr>
<th>Case</th>
<th>92</th>
<th>40</th>
<th>136</th>
<th>182</th>
<th>144</th>
<th>184</th>
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</thead>
<tbody>
<tr>
<td>Protest</td>
<td>1.00</td>
<td>0.75</td>
<td>0.50</td>
<td>0.25</td>
<td>0.00</td>
<td>-0.25</td>
</tr>
<tr>
<td>Submit</td>
<td>0.87</td>
<td>0.63</td>
<td>0.39</td>
<td>0.15</td>
<td>0.00</td>
<td>-0.15</td>
</tr>
</tbody>
</table>

Voices of borderline personality
My voice reacts to me

<table>
<thead>
<tr>
<th>Case</th>
<th>92</th>
<th>40</th>
<th>136</th>
<th>182</th>
<th>144</th>
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<td>0.23</td>
<td>0.00</td>
<td>-0.07</td>
</tr>
<tr>
<td>Submit</td>
<td>0.75</td>
<td>0.52</td>
<td>0.29</td>
<td>0.06</td>
<td>0.00</td>
<td>-0.06</td>
</tr>
</tbody>
</table>

All had hallucinations about being approached with transitive and controlling hostility (top section). The reaction was to protest and recoil (second section), and also to attack back (third section). The individual profiles for borderlines shown here are consistent with the implications of the group profile shown in figure 6.
within the total sample which includes all the diagnostic groups is found in a between-subject r using all subjects. Results were: “my voice focuses, I react,” ATK = 0.797 and CON = 0.460; “I focus on my voice, it reacts,” ATK = 0.708 and CON = 0.66. The high correlations for the ATK patterns suggest that the individuals whose voices were most attacking (centered on cluster 1–7) were those who reacted to the voice with the most protest and recoil (centered on cluster 2–7). Those who attacked the voice back tended to be those who experienced their voice as most protesting and recoiling. Complementarity in the control dimension was less marked, but still significant. For 28 degrees of freedom an r of 0.463 is significant at the 0.01 level. This finding means that across the total sample of 30 patients who had complete data sets, there was a tendency for those with controlling voices to submit to them (and/or for those with autonomy-giving voices to take autonomy), and for those who controlled their voices to experience the voice as submissive (and/or for those who gave autonomy to have voices which took autonomy).

Not all members of these diagnostic groups have a voice. To study connections among relationship with illness and chronicity, it will be important eventually to compare data on relationships with hallucinations to subsequent data obtained by asking patients to rate “my schizophrenia” (or my depression; or my mental illness) rather than, as was done here, my voice(s).

Discussion

The documentation of the existence of a well-articulated, interpersonally complementary and a sometimes friendly, sometimes hostile relationship with the auditory hallucination provides a promising method for studying the relationship with illness and self and chronicity. It also raises many other interesting questions, including “how did it start?”

Asking collaborating schizophrenic subjects to describe the first time they experienced their voice sometimes reveals that the voice appeared at a moment of extreme pain, when reality was too hard to bear. One prototype was offered by a person with paranoid schizophrenia who explained that her voice first appeared at age 10 when she was lying in bed at night, alone and terrified after another incestuous attack by her father. She said she felt so incredibly alone that it was unbearable, and she made up a “friend” who began to comfort her. Her conversations with this “friend” grew more frequent and more complicated as time and the abuse went on. When normal children experiment with imaginary companions, they have a chance to try out role reversal and different identities. Eventually, for normals, reality becomes more interesting and rewarding, and the imaginary companions disappear for lack of reinforcement. Perhaps for psychotics, reality is less reinforcing than fantasy.

Not all voices appear to have started as imaginary companions. Sometimes they began as obsessive thoughts. By either route, it seems reasonable to guess that the appearance of a hallucination is on a continuum with the normal process of introjection. In the first phase of introjection, the normal talks to himself or herself just as the internalized (parent) figure originally did. For example, the transgressing toddler says, “bad boy” to himself as he starts to do something for which he has been told: “bad boy.”

A normal adult might say to himself or herself when making a mistake: “What! Did you do that again?” and usually be unaware that those words probably are the (real or imagined) comments of an intimate. The process of introjection of the therapist may be observed during psychotherapy by patients who, during a crisis, say to themselves, “I wonder what [therapist’s name] would say now?” Eventually, the connection with the original object is forgotten and the patient’s new self-talk and the associated changes in behavior are his or her own. The psychotic, too, eventually forgets the beginnings, and insists the internalizations are outside of himself or herself; he or she may not recognize that the voice started as self-talk.

The boundary between realizing the voice is an internalization, a part of the “self,” and the extrusion to a force which is experienced outside the self was explained in the following conversation. A schizophrenic man revealed that the experience of a voice as separate from the self provided relief from obsessive thoughts, because then he could distance himself from the thoughts as “not him.” In this short passage, the patient also links the idea that going crazy is itself a choice that has positive aspects (see Mann 1986; Dillard, 1987).

Patient: It [the voice] “should nots” the things I would like to do, am expected to do. It’s a conflict between the two. I bargain with myself a lot. If there are three things I want to do, I bargain with one, choose one and chastise myself for doing the wrong thing.

I do function. It’s [the voice] not separate from myself. But I fight myself. Lately I think a lot
of things that don't make sense ...
... I have to bargain to do basic things, like go ... to buy food ...
... It [the voice] used to challenge me to do things that would be good for me like look for a job or meet people, but now sometimes it's real mean. It scares me. If I am really tired, or antagonized, it seems like it is another person.

Therapist: Would you feel better if it was another person?

Patient: Yes, better. It's easier to deal with then, more concrete. It's not like I don't know what I'm doing. I'll be obsessed with an idea, and then it stops when it becomes more distant. It's where I draw the line. This doesn't make sense.

Therapist: Yes, I think it does. If the idea is more distant, it is no longer in you, and that is more comfortable; it doesn't bother you all the time.

Patient: Yes, but isn't that weird?

Therapist: The worst part is that it is not benevolent.

Patient: Sometimes, it is. It tells me I'm okay if I'm really, really down. Then it's almost like it's someone there, a friend. So it's okay. That knows me better than anything else. It's a comfort. Even though it is mean, if it wasn't there, I'd be like everybody else and lose myself.

... But going crazy is a cop-out. You have people that are out of control. Nobody is crazy. You have a choice. It's easier to move into that realm. It's predictable. It's acceptable to be crazy. You have to go crazy—that's okay—or you have to get better. You can't stay in the middle group. What do you think of all this?

Therapist: I think you have wonderful insights.

Patient: I can't live in the world I want to live in. I have to live in the real world. We both give in to the real world.

Therapist: What world would you want to live in?

Patient: Don't ask. You shouldn't ask.

Therapist: Okay.

Patient: It's not a good place. It is self-nurturing, but not a good place ... my ideal is without shoulds and should nots. I get to be me instead of [given name].

Therapist: What is your name?

Patient: [Given name.] It's all [given name]. A lot of different people are in a person ...

Therapist: Did the voice have anything to do with your suicide attempts?

Patient: He told me to do it. "You should," he said. He also tells me when I can stop. I guess that is why I'm not dead. I gave him that area. We divided up.

Therapist: He has control of life and death?

Patient: Yes. I know he's out to the good. He'll get rid of all the crap. I have to give in to things he needs control over. He wouldn't kill me.

Later on, when listening with the therapist to a tape recorded family conference, this patient angrily noticed that the father passed responsibility for answering the therapist's questions to the mother. The patient accepted the suggestion that his passing of responsibility to the voice reflected the same pattern. For limited amounts of time, and on his own terms, he would discuss such similarities between his relationship with the voice and interactive patterns within the family.

The fact that a hallucination can be valued as an important companion and is cherished as well as dreaded by schizophrenic persons is supported by the fact that they often don't want to take neuroleptics because the drugs diminish or eliminate the strength of the voice.

One example:

Patient: I'm looking to leave ... I don't need any medicine ... I don't understand why, when you go into a hospital, if you're under a lot of stress they automatically dump all kinds of drugs on you ... They load you up on drugs and make you do the thorazine shuffle, you know....

Therapist: It's the side effect you don't like.

Patient: It's not the side effects; it's what they do to you mainly.

Therapist: What do they do to you mainly?

Patient: They take away your mind, bloat your body. Is that a side effect? That's doing to your mind and your body. That's not a side effect—that's taking away your whole entity.

Therapist: Can you say more about what you mean by take away your mind?

Patient: Except your soul. What?

Therapist: What does it mean to take away your mind?

Patient: To take away all your shoulds and should nots. I get to...

Therapist: You value your imagination.

Patient: I definitely value my imagination.

Later on, when listening with the therapist to a tape recorded family conference, this patient angrily noticed that the father passed responsibility for answering the therapist's questions to the mother. The patient accepted the suggestion that his passing of responsibility to the voice reflected the same pattern. For limited amounts of time, and on his own terms, he would discuss such similarities between his relationship with the voice and interactive patterns within the family.

The fact that a hallucination can be valued as an important companion and is cherished as well as dreaded by schizophrenic persons is supported by the fact that they often don't want to take neuroleptics because the drugs diminish or eliminate the strength of the voice.
not much chance that the later
more powerful creature will be
controlled by the ghost of the
person whom she succeeded.
[p. 8]

... instead of losing reason in
madness—and finding insanity
on the other side—that in reality,
I will lose insanity in madness—
and find a sound mind on the
other side. [p. 10]

The function of the voice as a
protective barrier is explicitly dis-
cussed in the following
correspondence. The “she” is the
fused with a girlfriend:

Patient: She tells me to be myself
... because sometimes I’m con-
fronted with people who are
always using extensions of them-
selves and I don’t know which
extension to take as being right, so I
go off and I say, well, maybe I’ll
respond to this extension, maybe
I’ll respond to that extension, you
know? ... I’ll say which extension
should I listen to, and then she’ll
say which extension do you want
to listen to, and I’ll say well, I
want to listen to the right one,
but they’re giving me so many
wrong extensions, and then she’ll
say well, respond to all the
wrong extensions and then show
them yourself, and that’s what I’ll
do. Is it okay if I go get another
light for my cigarette? [intervi-
wer says yes] No, when I’m
around people who don’t trust
me, I need to know how to
respond to their extensions, and I
need to have them know about
me, what I’m like, I’m just a basic
person, you know ....

Therapist: I believe that. I am try-
ing to get in touch with this.
You’re jumping away from me a
little bit.

Patient: Okay, okay.

Therapist: Do you feel that way
with me, like I’m giving you false
extensions?

Patient: You’re trying not to.
You’re trying real hard not to,
but you probably are insecure
too, and you don’t like to give
people your real self, so you give
people your extensions.

Therapist: What do you think my
real self is?

Patient: Oh probably real nice or
quiet and secure.

Therapist: And I give the ex-
sensions instead of what?

Patient: Instead of being nice and
quiet and secure.

Therapist: So in other words, I’m
kind of fending you off with my
extensions. Is that how it feels?

Patient: Ya.

Therapist: Hm. Do I remind you
of anybody you’ve known before?

Patient: You remind me of myself
when I was in the fourth grade.

Therapist: What were you like
then?

Patient: Terrible.

It appears that all the richness of
social interaction can also be found
in the internal world represented by
the voice. Many of the first person
accounts of mental illness (Kaplan
1964) attest to the convincingly
interpersonal nature of the relation-
ship with the hallucination. Daniel
Paul Schreber, for example, wrote
(Kaplan 1964, p. 132):

It [psychiatry] will have to recog-
nize the possibility that
occasionally the phenomena
under discussion may be con-
ected with real happenings,
which simply cannot be brushed
aside with the catchword
“hallucinations.”

Conclusion

This article examined a data set
which showed that psychotics were
able to rate their auditory halluci-
cinations on an interpersonal survey.
The results demonstrated the fol-
lowing: (1) All had integrated,
interpersonally coherent relation-
ships with their voice. (2) Those
relationships showed “interper-
sonal” complementarity in many
instances. (3) Qualitative differences
in the nature of the relationship
with the voice related meaningfully
to symptomatic differences among
the diagnostic groups. Hospitalized
acutely suicidal inpatients with bor-
derline personality or with
psychotic depression reported uni-
formly hostile and attacking voices.
A bipolar manic patient had a very
cordial, approving relationship with
his voice. Schizophrenic patients
also had integrated relations with
their voices, but within this group
more than others, complementarity
frequently failed, and is usually
seen clinically as “inappropriate
affect” and/or as responding with
unfamiliar contingencies.

Selected clinical excerpts sug-
uggested that the social “relationship”
with the hallucination may serve an
adaptive function. It follows that the
more adaptive the relationship with
the hallucination, the more intract-
able and chronic the illness. If this
can be documented by further
investigation, then one might con-
clude that treatment must confront,
on an individual basis, the function
of the hallucination and provide
more satisfactory social alterna-
tives. Such an application would not
include a regression to “blaming”
families but, rather, would provide
specific, clearly defined, constructive goals for changes in interactional patterns on the part of everyone in the social network.

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American Psychiatric Association. 


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Acknowledgments

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base. Patient participation during the last 2 years was the responsibility of Patricia Hanson and Paula Machtinger. All final patient diagnoses using the DIS, the Physician Interview Program, and the Linking Interview With Diagnostic Rules were by Patricia Hanson and Paula Machtinger; these project associates wrote the LIDR manual and loaded the database. Thanks and appreciation for very helpful comments on earlier drafts of this paper are expressed to the editors Sue E. Estroff and John S. Strauss, to Michael Moran, Craig Johnson, Mona Wasow, Marjorie Klein, Hans Strupp, and Steve Wonderlich.

The Author

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Announcement

The Theodore and Vada Stanley Foundation is pleased to announce the initiation of the New Support Program for Research on Serious Mental Diseases. The program will consist of Stanley Fellowship Awards—the purpose of which is to enhance research opportunities for those already in the field and to attract new researchers to the field. Special attention will be paid to neuroscience investigators with innovative approaches not funded by traditional research support mechanisms and to established investigators in other areas of medicine or neuroscience who wish to undertake research on diseases such as schizophrenia and bipolar disorder.

Stanley Fellowships will pay the researcher up to $50,000 per year, plus $20,000 per year in research costs for up to 3 years. Between three and five new awards will be given each year. The announcement of the first awardees will take place at the national convention of the National Alliance for the Mentally Ill in Cincinnati in July 1989.

Nominations for the awards will be made by members of the Selection Committee. Suggestions are welcome from senior researchers in the form of a one-page letter to the address listed below. A small group of nominees will then be invited to submit plans for the use of such an award.

For further information, please contact:

E. Fuller Torrey, M.D.,
Chairperson
Stanley Research Foundation
Awards Program
National Alliance for the Mentally Ill
2101 Wilson Blvd., Suite 302
Arlington, VA 22201