THE ACADEMIC LECTURE

PSYCHOTHERAPY OF SCHIZOPHRENIA[1]

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When I received the invitation to talk to you about psychotherapy of schizophrenia, I gave a good deal of thought to the question of how you might like me to approach the topic. Finally, I felt it might be most appropriate to report the development in the understanding and the technique of our clinical work since 1948 when I had the privilege to talk to you about it at the schizophrenia symposium during the annual meeting in Washington.

The goal of psychotherapy with schizophrenics was seen then, as it is now, as helping them by a consistent dynamically oriented psychotherapeutic exchange to gain awareness of the unconscious motivations for and curative insight into the genetics and dynamics of their disorder.

As a result of the continued research which is inherent in dynamic psychotherapy, I have gained some further insight into the dynamics of schizophrenic symptomatology from which have evolved some variations in the details of the treatment. Briefly, they are:

1. The old hypothesis according to which the schizophrenic's early experiences of warp and rejection were of over-all significance for the interpretive understanding and treatment has been somewhat revised.

2. The conflict-provoking dependent needs of schizophrenic patients have been seen more clearly.

3. The devastating influence of schizophrenic hostility on the patients themselves has been understood more clearly in connection with their states of autism and partial regression (weak ego—autistic self-depreciation).

4. This has led to a therapeutically helpful reformulation of the anxiety of schizophrenic patients as an outcome of the universal human conflict between dependency and hostility which is overwhelmingly magnified in schizophrenia.

5. The multiple meaning of some schizophrenic communications and its influence on the psychiatrist's interpretive endeavors has been clarified.

Before I begin to elaborate these topics, I have to ask you to forgive me for lack of reference to publications of other workers in the field. There is unfortunately not time enough to comment on the published work of our colleagues, to indicate what I owe to them, and also to develop my own conceptions. So, I felt I ought to decide to do the latter.

I would like to begin by stating that my discussion will comprise the treatment of hospitalized disturbed psychotics as well as that of manifestly less disturbed ambulatory patients whom we treat in the same way through all phases and all manifestations of their illness. This position is not new, but it has recently become more controversial due to opposite techniques which other authors have propagated.

From a social and behavioral standpoint and from the viewpoint of the special care which manifestly psychotic patients may need in order to be protected from harming themselves and others, the difference between these two types of patients may seem tremendous. Psychodynamically speaking, I see no difference between the symptomatology of actively psychotic and more conformative schizophrenics.

All schizophrenic patients live in a state of partial regression to early phases of their personal development, the disturbed ones more severely regressed than the conformative ones. All of them are also living simultaneously on the level of their present chronological age, the conformative ones more obviously so than the severely disturbed

[1]Read at the 110th annual meeting of The American Psychiatric Association, St. Louis, Mo., May 3-7, 1954. The three papers that follow are discussions of this lecture.

ones. Irrespective of the degree of regression and disturbance, we try to reach the regressed portion of their personalities by addressing the adult portion, rudimentary as this may appear in some severely disturbed patients. Also, the general psychodynamic conception that anxiety plays a central role in all mental illnesses and that mental symptoms in general may be understood simultaneously as an expression of and as a defense against anxiety and its underlying conflicts holds regardless of the severity of the picture of illness, and regardless of its more or less dramatic character. Hence we make the exploration of the dynamic roots of the schizophrenic's anxieties our potential goal through all phases of illness.

Lack of immediate communicative responses to treatment in acutely disturbed patients is no measuring rod for their actual awareness of and for their inner response to our psychotherapeutic approach. This old experience has been further corroborated in more recent dealings with several recovered patients. They did refer to various aspects of our psychotherapeutic contacts, after their emergence, while we were working through the dynamics of their problems, or later while we were reviewing treatment and illness during the recovery period.

While symptomatic psychotherapy of acute psychotic manifestations may be necessary with some patients, for situational reasons, many of us consider it not too important to be overconcerned with the duration of the acutely disturbed states of patients while they are under psychotherapy.

My experience during the last 20 years has been mainly with schizophrenic patients who came to our hospital in a state of severe psychotic disturbance, from which the majority emerged sooner or later under intensive dynamic psychotherapy. After their emergence, they continued treatment with the same psychiatrist through the years of their outwardly more quiet state of illness, with the aim of ultimate recovery with insight. During both phases the patients were seen for 4 to 6 regularly scheduled weekly interviews lasting one hour or longer. Sometimes relapses occurred. Such relapses were due to failure in therapeutic skill and evaluation of the extent of the patient's endurance for psychotherapy, to unrecognized difficulties in the doctor-patient relationship, or to responses to intercurrent events beyond the psychiatrist's control. As a rule, these relapses could be handled successfully if the psychiatrist himself did not become too frightened, too discouraged, or too narcissistically hurt by their occurrence.

From the experience with these patients we learned about one more reason for advocating the same type of psychotherapeutic approach through all phases of the illness: part of the work which a patient has to accomplish during treatment and at the time of his recovery is, in my judgment, to learn to accept and to integrate the fact that he has gone through a psychotic illness, and that there is a "continuity," as one patient called it, between the person as he manifested himself in the psychosis and the one he is after his recovery. The discussion of the history of patients' illness and treatment after their recovery serves of course the same purpose. This is in contrast to the therapeutic attitude of some psychiatrists who hold that recovering patients should learn to detest and eject their psychotic symptomatology, like a foreign body, from their memory.

The difficult task of integrating the psychotic past, which we advocate, will be greatly facilitated if it can be done on the basis of patient's memory of a psychiatrist who has maintained the same type of psychotherapeutic relationship with them through the whole course of treatment. Changes in the doctor's therapeutic approach may easily become a mirror of the lack of continuity in the patient's personality, and, incidentally, may become an inducement for patients to dwell in one or the other phase of their illness, depending upon their preference for this or the other type of therapeutic relationship.

The following experience with a patient illustrates the difficulties of integrating the experience of a past psychosis.

This patient emerged from a severe schizophrenic disturbance of many years duration, for which she was finally hospitalized for 2 years at Chestnut Lodge and then treated as an ambulatory patient for another 2 years. Eventually she became free of her psychotic symptomatology except for the maintenance of one manifest symptom: she would hold on to the habit of pulling the skin off her heels

to the point of habitually producing open wounds. No attempt at understanding the dynamics of this residual symptom clicked, until the patient developed one day an acute anxiety state in one of our psychotherapeutic interviews in response to my commenting on favorable "changes" that had taken place in her. After that, the main dynamic significance of the skin-pulling became suddenly clear to her and to me. "I am still surprised and sometimes a little anxious about the change which I have undergone," she said, "and about finding and maintaining the continuity and the identity between the girl who used to be so frightfully mixed up that she had to stay locked up on the disturbed ward of Chestnut Lodge, and the popular and academically successful college-girl of today." The skin-pulling as a symptom similar to another self-mutilating act of burning herself, which she repeatedly committed while acutely ill, helped her to maintain her continuity. It made it possible to be ill and well at the same time, because it was only she who knew about the symptom which could be hidden from everybody else with whom she came in contact as a healthy person. After this discovery, the symptom eventually disappeared.

Incidentally, important as the understanding of this one dynamic aspect of the patient's symptom was for therapeutic reasons, this does not mean that it constituted its only significance.

It was stated that mental symptoms in general can be understood as a means of expressing and of warding off anxiety and the central conflicts which are at the root of this anxiety, and that the exploration of this anxiety is most important in psychotherapy with schizophrenics. If this is true, we have to ask for a specific psychodynamic formulation of the causal interrelatedness between schizophrenic symptomatology and the conflicts underlying the anxiety in schizophrenic patients. A correct workable conception of the psychodynamic correlation between anxiety and schizophrenic symptom-formation is a prerequisite for the development of a valid method of dynamic psychotherapy with schizophrenic patients.

We know the historically determined deadly fear of schizophrenics of being neglected, rejected, or abandoned, and their inability to ask for the acceptance and attention they want. Consequently, most psychiatrists who did psychotherapy with schizophrenics in the early days suggested treating them with utter caution, as I did, or with unending maternal love, permissiveness, and understanding as did Schwing and more recently Sechehaye. While doing so, psychiatrists faced another dynamically significant problem of the schizophrenic, the unconscious struggle between his intense dependent needs and his recoil from them. These we learned to understand genetically as the correlate to the patients' experience of neglect by the "bad mother" at a time when her attention was indispensable for the infant's and the child's survival.

We also know about the resentment, anger, hostility, fury, or violence, with which the infant and child, the "bad me" as Sullivan called it, and later the schizophrenic patient, responds to the early damaging influences of the "bad mother," as he experienced her.

In order to understand the devastating significance of this hostility for schizophrenic patients, we have to realize the following developmental facts of their lives. As we first learned from Freud and Bleuler, schizophrenics are people who responded to the early misery of their interpersonal contacts not only with anger and hostility, but also with a partial regression into an early state of ego-development and of autistic self-concern and self-preoccupation. This early traumatization and the partial regression make for a weak organization of the schizophrenic's ego. Consequently, he feels more threatened than other people by all strong emotional experiences, and above all, by the realization of his own hostile impulses.

Another reason for the specific hardship which schizophrenic hostility creates for the patients is that their autistic self-preoccupation makes for their being painfully concerned with their own "bad me," with their own hostility and fury, or their fantasies of violence and destruction against themselves and others.

Besides, their grandiose concept of power in these states of regression to an early state of interpersonal development makes for their preoccupation with themselves as more or less dangerous people.

Where other types of patients are mainly concerned with the fear of disapproval, of the withdrawal of love which they may elicit in other people by their hostile impulses or other emanations of their "bad me," schizophrenic patients are more concerned with their own status as dangerously hostile peo-

ple, with the damage which may be done to others who associate with them, and with their impulses of punitive self-mutilation.

Yet, neither the fearful and grandiose self-preoccupation with his dangerous hostility, nor the threat of the primary abandonment by mother, nor the resulting dependent needs from which the patient simultaneously recoils, nor the secondary rejection he may have elicited in the mother and other significant persons in his environment because of his "badness" are in themselves potent enough to elicit schizophrenic anxiety.

Schizophrenics suffer, as all people in our culture do even though to a much lesser degree, from the tension between dependent needs and longing for freedom, between tendencies of clinging dependence and of hostility. For the above-mentioned reasons the degree of the schizophrenic's need for dependency, the extent to which he simultaneously recoils from it, and the color and degree of his hostile tendencies and fantasies toward himself and others are much more intense than in other people. As a result, the general tension engendered by the clash of each of these single powerful emotional elements becomes completely overwhelming. In other words, the quantitative difference between the schizophrenic's anxiety and similarly motivated tensions in people who have not been emotionally traumatized as early in life as the schizophrenic, and who could therefore develop a stronger ego organization, is so great that it acquires a totally different quality. It is this tremendous volume of the schizophrenic's anxiety which makes it unbearable in the long run. It then has to be discharged by symptom-formation; *i.e.*, schizophrenic symptomatology is seen as the expression of and defense against schizophrenic anxiety, engendered by the tremendous tension between his great dependent needs, his fear to give them up, his recoil from them, his hostility, his thoughts and fantasies of destructiveness against himself and others.

In delineating the dynamic interrelatedness between schizophrenic anxiety and symptomatology, I do not claim, of course, to solve the total problem of schizophrenic symptomatology. I am referring only to such portions of the dynamics as seems necessary for the clarification of my therapeutic conceptions. Our treatment of many schizophrenic manifestations has been corrected or markedly improved in the light of the hypothesis offered.

Take for example the meaning of the schizophrenic's "fear of closeness," a formulation which, incidentally, has been much abused. In the early years of psychotherapy with schizophrenics we used to understand this fear of intimacy as an expression of anxiety that all closeness, much as it was simultaneously desired, might be followed by subsequent rejection; then we learned that this fear of closeness seemed also strongly determined by the fear which the partially regressed schizophrenic with his weak ego-organization felt, that closeness might endanger his identity, might destroy the boundaries between his own ego and that of the other person.

In the meantime, I learned from my work with quite a number of further patients, that their fear of closeness is tied up with their anxiety regarding the discovery of their secret hostility or violence against persons for whom they feel also attachment and dependence. They give a mitigated, non-dangerous expression to this hostility, and try simultaneously to hide it as a secret by staying away from people.

Let me mention, in this context, an experience which I had repeatedly with patients whom I saw in an office connected with my home: they became tense and anxious when we met after my secretary and maid had left the house. The patients commented on the lack of protection against their hostile impulses.

One young paranoid patient formulated this outrightly, by asking, "Do you realize that I can knock you down in no time?" Unfortunately, I became preoccupied with my role of demonstrating the lack of fear which at the time was luckily mine. Thus, I failed to notice how frightened the patient felt by the realization of his potential violence against a woman doctor, with whom he had established at the same time a dependent relationship. Later on I realized that he was warning me against and asking for protection from future acts of violence, by which he felt we were both threatened. Subsequently, such threats against me or other doctors whom he accidentally saw in my house, against the house itself, and against the attendants who came to take care of him, were the unfortunate

result. All these assaultive acts were accompanied by marked signs of anxiety.

I continued seeing the patient in a wet pack, until he agreed to abstain from all violent actions and to express his hostile feelings verbally. This he did for some time, alternately with verbal expressions of his dependent attachment and with nonverbal signs of anxiety, until he developed a marked manifest psychotic symptomatology. Since then, it became more difficult to have the patient face his dependent needs and his hostility or the anxiety engendered by both. Had I caught on immediately to the patient's anxiety regarding his own hostility, he might have been spared the necessity of transforming it into overt psychotic symptomatology.

Let us now take a look at states of catatonic stupor in the light of our hypothesis. I believe it is of interest to state that many clinicians have been accustomed to describe stuporous states as a result of the schizophrenic's withdrawal of interest from outward reality. Hence the oversimplification of interpreting them only as a response to catatonic fear of rejection becomes quite understandable.

Actually, a patient in stupor has not withdrawn his interest from the environment. As we know from reports about the experiences while in stupor, which these patients furnish after their emergence, they are, more frequently than not, keen observers of what is going on in their environment. Withdrawal of the ability for interpersonal communication is what characterizes the condition of the patient in stupor, not withdrawal of interest in the environment *per se*. As we know now, this comes about not only in response to the threat of rejection by others, but much more for fear of the patient's own hostility or violence in response to actual or assumed acts of rejection from other people.

I remember in this connection the catatonic patient previously reported who became stuporous when she did not receive my message that I had to postpone a scheduled interview. Upon discovering this unfortunate omission, I painstakingly explained the situation to the patient. When she heard and understood me, she emerged from the stuporous state and psychotherapeutic contact could be resumed.

Incidentally, while telling you about my therapeutic approach to this or other patients, I have to fight off a temptation to dramatize; this in spite of the fact that dramatization does certainly not go with what I would consider good taste in delivering a scientific paper. Upon asking myself about the reason for this temptation, I discovered that actually it is not as illegitimate as it appears to be. It is promoted by the fact that I feel inclined to duplicate tone and inflections of the patient's and my voice, the concomitant gestures, changes in facial expression, etc. This comes about because the doctor's nonverbal concomitants of the psychotherapeutic exchange with schizophrenic patients, in and outside of manifestly psychotic episodes, are equally if not at times more important than the verbal contents of our therapeutic communication.

The particular emotional stimulus to which a stuporous schizophrenic will respond, which instigated this digression, must be much stronger than one that can be produced by the content *per se* of what is said. An academic type of delivery to the patient will not do the trick.

Of course, to a certain extent nonverbal elements play a great role in all interpersonal communications, but the degree of expressive skill with which the patient himself uses means of nonverbal communication, and his specific sensitivity to the meaning of its use by the psychotherapist is such that for all practical purposes the difference in quantity, here again, turns actually into one of quality.

This great perceptive sensitivity of schizophrenic patients was one of the reasons for my overcautious approach to them in bygone times. We used to look at the sensitiveness of these patients in a merely descriptive way and labelled it as one of their admirable characteristics. If we investigate it psychodynamically we realize that it develops actually in response to their anxiety as a means of orientation in a dangerous world, and we can use it as a signpost on our road toward the psychodynamic investigation of schizophrenic anxiety. Also we should not overlook the possibility that many of the initially correct results of the schizophrenic's perceptive sensitivity may be subsequently subject to distorted psychotic interpretation and misevaluation.

To return to our discussion of the psychodynamics of states of catatonic stupor, I too used to interpret them as a sign only of the

patients' having withdrawn because of the lack of consideration or rejection of them. I believe now that this is neither the primary nor the only cause, and that withdrawal into stupor is more strongly motivated by the anxiety of patients who realize the danger of their own hostile responses to such neglect by people on whom they depend and to whom they are attached. Several patients corroborated the validity of this hypothesis by spontaneous comments after their recovery.

The symptoms that patients in stupor show concomitant with their withdrawal of interest from communication furnish another proof. Stuporous patients regress to a period of life when they used food-intake and elimination as an expression of their hostility against and of their wish to exert control over their environment.

The hostile meaning of disturbances in elimination can also be demonstrated outside of stuporous states. I had impressive proof of it in my dealings with a schizophrenic woman patient, who is also mentioned in the Stanton and Schwartz paper, "A Social Psychological Study of Incontinence."

One day, this patient urinated, before I came to see her, on the seat of the chair on which I was supposed to be seated during our interview. I did not see that the chair was wet. The patient did not warn me and I sat down. I became aware of the situation only after the dampness had penetrated my clothing. I thereupon expressed my disgust in no uncertain terms. Then I stated that I had to go home. The patient asked anxiously about my coming back, which I refused with the explanation that the time allotted to our interview would be over by the time I would have taken a bath and attended to my soiled clothes.

Obviously, the patient's wetting my chair was an expression of hostile aspects in her dependent relationship with me. However, I did not say so in so many words, because I felt that the verbalization of this insight should come from the patient. In subsequent discussions of the event, she responded first with symptom-formation and nonverbal communication, wavering back and forth from expressions of hostility against me to expressions of attachment and dependence, until she was finally able to reveal that this had been a planned expression of resentment against me. The patient wished to punish me for what she had experienced as excessive therapeutic pressure during an interview preceding the chair-wetting.

Certain symptoms of several hebephrenic patients of our observation could also be psychodynamically understood and therapeutically approached as an expression of the anxiety connected with their hostility toward people on whom they likewise felt extremely dependent. These patients withdrew their interest from their interpersonal environment except for a kind of tolerant and peaceful, if incomprehensible, give-and-take with some of their fellow patients, until it all was suddenly interrupted by an outburst of hostility against these patients or against the personnel. As far as their dealings with me went, they did what hebephrenic patients will do at times, as we all know: a kind of mischievous smile or laughter accompanied or interrupted their scarce communications or was in itself the only sign of their being in some kind of contact with me. Two patients stated, after they were ready to resume verbal contacts with me, that their laughter was a correlate of hostile derogatory ideas against and fantasies about me. As they at last established a close relationship of utter dependence upon me, this was accompanied by a marked increase in intensity and duration of these spells of derogatory, tense laughter. The anxiety connected with the establishment of a dependent relationship expressed itself and was warded off by the increased derogatory laughter. The laughter subsided eventually, in response to the psychotherapeutic investigation and the working through of the various aspects of the patients' relationship with me.

With regard to paranoid patients, one of their dynamisms is, as we know, that they project onto others the blame for what they consider blameworthy in themselves. Upon investigation of the contents of their blameworthy experiences we always discover that they are extremely hostile in nature. The suspiciousness of these people points in the same direction.

Again, their suspicion and hostility increase parallel with the realization of their friendly dependent relationship with the psychiatrist. This showed quite impressively in the above-mentioned violent man patient. The fact that the office where we initially met was part of my home became to him, to use Mme. Sechehaye's expression, a "symbolic realization" of his wish to be my friend and houseguest. As he fantasied that

I shared his wishes and hallucinated that he heard me say so, he became more and more hostile and anxious.

If our hypothesis about the interrelatedness between craving for and recoiling from dependency, dangerous hostility and violence against themselves and others, overwhelming anxiety and schizophrenic symptomatology is correct, we must ask how the therapeutic approaches of consistent love and permissive care, as they used to be given to schizophrenic patients by some therapists, including myself, could be helpful. We used to think that they were successful (1) because they gave a patient the love and interest he had missed since childhood and throughout life; (2) because his hostility could subside in the absence of the warp which had originated it; and (3) because the patient was helped to re-evaluate his distorted patterns of interpersonal attitudes toward the reality of other people.

We now realize that what we have long known to be true for neurotic patients also holds true for schizophrenics. The suffering from lack of love in early life cannot be made up for by giving the adult what the infant has missed. It will not have the same validity now that it would have had earlier in life. Patients have to learn to integrate the early loss and to understand their own part in their interpersonal difficulties with the significant people of their childhood.

I also know now, and can corroborate this with spontaneous statements of recovered patients, that the love and consideration given to them is therapeutically more significant because they interpret it as proof that they are not as bad, as hostile in the eyes of the therapist, as they feel themselves to be.

The few fragments of therapeutic exchange with patients quoted so far may serve as examples of the change in our psychotherapeutic attitude, part of which I already elaborated in my contribution to the 1950 Yale Symposium on Psychotherapy with Schizophrenics.

Of course, we give our schizophrenic patients all the signs of empathic consideration that they need because they suffer. If possible, we prefer to do so by implication or in nonverbalized innuendoes. Too marked sympathetic statements may enhance fear of intimacy and they may unnecessarily increase patients' dependence on the therapist, putting into motion the psychopathological chain of dependent attachment, resentment, anxiety, symptom-formation.

However, we no longer treat the patients with the utter caution of by-gone days. They are sensitive but not frail. If we approach them too cautiously, or if we do not expect them to be potentially able to discriminate between right and wrong, we do not render them a therapeutically valid service. We contribute to their low self-evaluation, instead of helping them to develop a healthier attitude toward themselves and others.

Also, if there was lack of parental interest in infancy, this entails lack of guidance in childhood. This fact deserves more therapeutic consideration than it has been given so far. There are therapeutically valid variations of the guidance needed and missed in early childhood, which can be usefully included in psychotherapy with schizophrenics in adulthood.

One exuberant young patient, the daughter of indiscriminately "encouraging" parents, was warned against expecting life to become a garden of roses after her recovery. Treatment, she was told, should make her capable of handling the vicissitudes of life which were bound to occur, as well as to enjoy the gardens of roses which life would offer her at other times. When we reviewed her treatment history after her recovery, she volunteered that this statement had helped her a great deal, "not because I believed for a moment that you were right, doctor, but because it was such a great sign of your confidence in me and your respect for me, that you thought you could say such a serious thing to me and that I would be able to take it."

In line with our attempts at raising patients' low opinion of themselves, we replace offers of interpretations by the therapist, if possible, by attempts at encouraging patients to find and formulate their interpretations themselves, as demonstrated in my exchange with the patient who wet the chair.

So far we have discussed the psychodynamics of schizophrenics symptom-formation in general as a response to their anxiety. Let us now consider the double and multiple meaning that is inherent in many of the schizophrenic's cryptic and distorted manifestations. Many of them elude the psychiatrist's understanding, but they may yield indirectly to therapeutic endeavors in

other areas. Insight into their dynamics may thus be gained in subsequent discussions.

Others, such as hallucinations and delusions, I found frequently accessible to a direct psychotherapeutic approach. They would be successfully examined with the patient as they occurred in his experience and in terms of his own formulations. I stated, however, explicitly to the patient that I did not share his hallucinatory or delusional experience.

There is one more access to understanding schizophrenic communications which has not been mentioned as yet. Schizophrenics are able to refer in their productions simultaneously to experiences from the area of their early childhood, from their present living in general, and, if they are under treatment, from their relationship with the therapist, like dreamers do in their dreams. Sometimes we are able to understand the meaning of and their reference to various chronological levels of the patients' experience, sometimes not.

At any rate, it is most important for the psychiatrist to realize this multiple meaning of many schizophrenic symptoms and communications. This realization should make us replace the old therapeutic attitude that therapists ought to be able to find and offer to the patient the only correct meaning of a symptom or communication by the suggestion that they should train themselves to become able to feel which of several meanings of a schizophrenic symptom or communication (if they catch on to several of them) is the therapeutically most significant one at a given time. This ability of the psychiatrist to select sensitively when and what to present to the patient is most desirable, because of the narrowed ways of the schizophrenic's thinking and their short span of attention which limits their capacity to listen.

The insights into the possibilites and the limitations of understanding schizophrenic communications should do away with the endless discussion that used to go on between various members of groups of psychotherapists as to whether a patient's communication in word or action meant only what Dr. A. heard or exclusively what Dr. B. heard. Depending upon the scope of personal and clinical experience and the personality of the therapist and on his ability to understand patients' communications via identification, each among several psychotherapists may catch on to one of the different meanings of a patient's communication.

The insight into the manifold meanings of patients' symptoms or other manifestations may also do away with the continuing discussions in our literature of the question whether or not schizophrenic patients understand their own communications. I believe it should be stated that they sometimes do and sometimes do not. Sometimes they may, above all, be aware of the descriptive content of their communication, but not of its dynamic significance. While this whole question holds great theoretical interest, I believe now that for therapeutic purposes its solution is not too important. This holds true all the more since the main trends in treatment no longer go in terms of translating the descriptive meaning of the content of any single symptom.

There are two facts that have led us more and more away from working with patients in terms of interpreting their various symptoms and other cryptic communications. One is negative and is determined by the fact that most isolated interpretations of the content of a single symptom or other communication will not cover all its meanings in a therapeutically significant way. The other is an important positive one: it follows from the knowledge of the psychodynamic fact that schizophrenic patients, like any other mental patients under treatment, repeat with the therapist the interpersonal experiences which they have undergone during a lifetime.

Hence we have moved increasingly in the direction which I have already elaborated in previous papers: we make the therapeutic exploration and clarification of schizophrenic anxiety and symptomatology, as they manifest themselves in the patient-doctor relationship, as integral a part of psychotherapy with schizophrenics as it is with neurotic patients. Some modifications are, of course, required in view of the difference between schizophrenic and neurotic modes of relatedness with the psychiatrist and with other people. But in both cases, our therapeutic attention is focused on the dynamic investigation and clarification of the conscious and the un-

conscious aspects of the patient-doctor relationship in its own right and in its transference aspects. Special attention is paid to the exploration of the anxiety aroused by the therapist's probing into the patients' problems, and to their security operations against it.

Here is an example from the treatment history of the patient who pulled the skin off her heels, which illustrates both the multiple meaning of schizophrenic symptoms on various experiential levels and our approach to its basic dynamic significance in terms of investigating its manifestations in the patient-doctor relationship:

We are already familiar with the dynamic validity of the skin-pulling as a way for the patient to establish her "continuity." As we learned in the course of its further investigation, the localization of this symptom was determined by mischievously ridiculing memories of her mother's coming home from outings to prepare a meal for the family, going into the kitchen, removing shoes and stockings but not coat and hat, and walking around the kitchen on bare feet.

The self-mutilating character of the symptom proved to be elicited by the patient's resentment against me. In her judgment, I misevaluated the other act of self-mutilation from which she suffered during her psychotic episodes, the compulsion of burning her skin. The patient thought of them as a means of relieving unbearable tension, whereas she felt that I thought of them only as a serious expression of tension. In maintaining the skin-pulling, while otherwise nearly recovered, she meant to demonstrate to me that skin injuring was not a severe sign of illness.

During the treatment period after the dismissal from the hospital, the patient tried for quite a while to avoid the recognition of her hostility against me and the realization of her dependent attachment to me which she resented, by trying to cut me out of her every-day life. She did so, repeating an old pattern of living in two worlds, the world which she shared with me during our therapeutic interviews, and life outside the interviews, during which she excluded me completely from her thinking. Previously, the patient had established this pattern with her parents by living for 11 years in an imaginary kingdom which she populated by people of her own making and by the spiritual representations of others whom she actually knew. They all shared a language, literature, and religion of her own creation. Therapeutic investigation taught us that the patient erected this private world as a means of excluding her prying parents from an integral part of her life. It was her way of fighting her dependence on them and of demonstrating how different she was from them in all areas where she disliked and resented them.

The patient recognized the significance of the dichotomy in her dealings with me as a means of escape from her resentment against and dependence on me, only after going twice through a sudden outburst of hostility and anxiety which led to brief periods of re-admission to the hospital where she regressed to her old symptom of burning herself.

After a few stormy therapeutic interviews, she understood the dynamic significance of her need for readmission; she felt so dependent on me and so hostile against me that she had to come back to live in the hospital and to burn her skin.

During the ambulatory treatment periods which followed, the patient learned eventually to recognize that her excluding me from one part of her life was a repetition of the exclusion of her parents from her private kingdom. After that, she saw too that her resentment against me was also a revival of an old gripe against her parents; they had a marked tendency to make her out to be dumb, as I tried to do, in her judgment, by putting over her my misevaluation of the skin burning. They kept her for many years in a state of overdependence, as I had done too, by virtue of our therapeutic relationship.

All these transference facets of the patient's relationship with me, as well as the problems of the doctor-patient relationship in their own right had to be worked through several times before the patient could ultimately become free from her interpersonal difficulties with me, with her parents and other people, and from the anxiety which they engendered.

While we consider the suggestions about psychotherapy with schizophrenics, which we have offered, to be psychodynamically valid and helpful rules, we believe, on the other hand, that the ways and means to go about using them will be inevitably subject to many variations, depending on the specific assets and liabilities of the personality of the therapist, and, hence, on the specific coloring of his interaction with his patient.

Psychotherapy with schizophrenics is hard and exacting work for both patients and therapists. Every psychiatrist must find his own style in his psychotherapeutic approach to schizophrenic patients. About technical details such as seeing patients only in the office, walking around with them, seeing them for nonscheduled interviews I used to have strong feelings and meanings. Now I consider them unimportant, as long as the psychotherapist is aware of and alert to the dynamic significance of what he and the patient are doing, and what is going on between

them. What matters is that he conducts treatment on the basis of his correct appraisal and exploration of the psychodynamics of the patient's psychopathology and its manifestations in the doctor-patient relationship. Successful histories of treatment with the principles suggested, but conducted in various and sundry interpersonal and environmental settings, are a living proof of the validity of my present corrected attitude.

Since the work with schizophrenics makes great and specific demands on the psychiatrist's skill and endurance, no discussion of psychotherapy with schizophrenics is satisfactory as long as the consideration of the specific personal problems of the therapist is omitted. In view of the extensive previous discussions of this topic by others and by myself, I shall only briefly enumerate the specific problems and requirements which ought to be met and solved by psychiatrists who wish to work with schizophrenics: they should be able to realize and constructively handle unexpected emotional responses, such as fears or anxieties, at times inevitably aroused in each of them by anxious, violent, overdependent, or lonely schizophrenic patients.

There is one special point I might add. Psychotherapists who share the fear of loneliness, which is the fate of men in our time, must watch out specifically lest their need to counteract their own loneliness make them incapable of enduring the inevitable loneliness and separation that their schizophrenic patients may bring home to them in their isolating cryptic communications. An undesirable urge to translate cryptic schizophrenic communications prematurely may interfere in such therapists with the more sound tendency to patiently wait and listen to the patients' own explanations of their communications.

Summary

1. The goal of dynamic psychotherapy with schizophrenics is the same as that of intensive psychotherapy with other mental disturbances, i.e. to help both ambulatory and hospitalized patients gain awareness of and curative insight into the history and unknown dynamic causes which are responsible for their disorder.

2. The same type of psychotherapeutic approach to schizophrenic patients during all phases and manifestations of the disorder and discussions of illness and treatment after their recovery are recommended for the purpose of helping such patients to integrate their recovery with their psychotic past.

3. An attempt is made to understand schizophrenic symptomatology and to approach it therapeutically as an expression of and as a defense against anxiety. The hypothesis is offered that the universal human experience of tension between dependency, fear of relinquishing it, recoil from it, and interpersonal hostility becomes, in the case of schizophrenic persons, so highly magnified and so overwhelming that it leads to unbearable degrees of anxiety and then to discharge in symptom-formation.

4. The multiple meaning of many schizophrenic symptoms, communications, and other manifestations has been discussed. The need for understanding and translating them descriptively for therapeutic reasons has been questioned, and the significance of nonverbal communications with schizophrenic patients has been stressed.

5. Psychodynamic investigation and clarification of schizophrenic anxiety and symptomatology in its conscious and unconscious manifestations in the patient-psychiatrist relationship is presented to be equally as crucial for the psychotherapy with schizophrenics as for other mental patients.