Notes on the Development of Treatment of Schizophrenics by Psychoanalytic Psychotherapy†

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IN THE PREANALYTIC PHASES of psychiatric development, psychotherapists considered schizophrenic states nontreatable. There seemed to be no medium in which the disturbed schizophrenic and the psychiatrist could communicate with one another. The thought processes, feelings, communications, and other manifestations of the disturbed schizophrenic seemed nonsensical and without meaning as to origin, dynamics, and actual contents.

Psychoanalysts know that all manifestations of the human mind are potentially meaningful. This refers equally to the psychotic manifestations of the disturbed schizophrenic while awake and to the transitory psychotic productions of the mentally healthy dreamer while asleep. Schizophrenic thought processes and means of expression have been successfully studied by Betz, Bleuler, Cameron, Goldstein, Hanfmann, Kasanin, Storch, Sullivan, Vigotsky, and others.[1] Their parallelism with dream processes has been constructively emphasized by Freud, Jung, Sullivan, Federn, and the writer.[2] It is now generally recognized that the communications of the schizophrenic are practically always meaningful to him, and potentially intelligible and not infrequently actually understandable to the

[1] Barbara J. Betz, "A Study of Tactics for Resolving the Autistic Barrier in the Psychotherapy of the Schizophrenic Personality," *Amer. J. Psychiatry* (1947) 104:267-273.

P. E. Bleuler, "Dementia praecox oder Gruppe der Schizophrenien" (in) *Handbuch d. Psychiatrie,* edited by G. Aschaffenburg; Leipsig and Wien, Franz Deuticke, 1911.

Norman Cameron, "Reasoning, Regression and Communication in Schizophrenics," *Psychological Monographs,* (1938) No. 221.

T. M. French and J. S. Kasanin, "A Psychodynamic Study of the Recovery of Two Schizophrenic Cases," *Psychoanalytic Quart.* (1941) 10:1-22.

Kurt Goldstein, "Methodological Approach to the Study of Schizophrenic Thought Disorder" in *Language and Thought in Schizophrenia: Collected Papers,* edited by J. S. Kasanin; University of California Press, 1944; pp. 17-40. "The Significance of Special Mental Tests for Diagnosis and Prognosis in Schizophrenia," *Amer. J. Psychiatry* (1939) 96: 575-588. "The Significance of Psychological Research in Schizophrenia," *J. N. and M. Disease* (1943) 97: 261-279.

E. Hanfmann, "Analysis of Thinking Disorder in a Case of Schizophrenia," *Arch. Neurol. and Psychiat.* (1939) 41:568-579.

E. Hanfmann and J. S. Kasanin, "An Experimental Study of Concept Formation in Schizophrenia," *Amer. J. Psychiatry* (1938) 95:35-52. "Conceptual Thinking in Schizophrenia," Monograph No. 67, Nervous and Mental Disease Publishing Co., 1942.

J. S. Kasanin, "The Disturbance of Conceptual Thinking in Schizophrenia," in *Language and Thought in Schizophrenia: Collected Papers,* edited by J. S. Kasanin; University of California Press, 1944; pp. 41-49.

Nolan D. C. Lewis, *Research in Dementia Praecox;* New York, National Committee for Mental Hygiene, 1936.

A. Storch, "The Primitive Archaic Forms of Inner Experiences and Thought in Schizophrenia," *J. N. and M. Disease,* Monograph No. 36, 1924.

Harry Stack Sullivan, "The Language of Schizophrenia," in *Language and Thought in Schizophrenia: Collected Papers,* edited by J. S. Kasanin; University of California Press, 1944; pp. 4-16. *Conceptions of Modern Psychiatry;* Washington, D. C., The William Alanson White Psychiatric Foundation, 1947.

L. S. Vigotsky, "Thought in Schizophrenia," *Arch. Neurol. and Psychiat.* (1934) 31:1063-1077.

[2] Paul Federn, "Psychoanalysis of Psychoses," *Psychiatric Quart.* (1943) 17:3-19, 246-257, 470-487.

Fromm-Reichmann, "Psychoanalytic Psychotherapy With Psychotics," PSYCHIATRY (1943) 6:277-279. "Remarks on the Philosophy of Mental Disorder," PSYCHIATRY (1946) 9:293-308.

C. J. Jung, *The Psychology of Dementia Praecox;* New York, Nervous and Mental Disease Publishing Co., 1936; Monograph No. 3.

Sullivan, "Affective Experience in Early Schizophrenia," *Amer. J. Psychiatry* (1927) 6:467-483. "Environmental Factors in Etiology and Course Under Treatment of Schizophrenia," *Med. J. and Record* (1931) 133:19-22.

* For biograhpical data, see PSYCHIATRY (1946) 9:293. For bibliography, see Reference Lists section of this issue.

† Contributions to the round-table discussions on psychotherapy of schizophrenia at the annual meetings of the American Psychoanalytic Association and of the American Psychiatric Association, May 1948, in Washington, D. C.

trained psychoanalyst. It was not the nature of the schizophrenic communication therefore that constituted an obstacle to psychoanalytic psychotherapy with schizophrenics.

The reluctance to apply psychoanalytic knowledge and technique to the psychoses stems from Freud's paper on narcissism.[3] This concept of the narcissistic origin and the regressive character of schizophrenic disorders excluded, according to him, the possibility of establishing a workable relationship between the schizophrenic and the psychoanalyst.

Subsequent revisions have led to changes in Freud's concept. It is true that the schizophrenic is hit by initial traumatic warp and thwarting experiences at a very early period of life when he has not yet developed a marked and stable degree of relatedness to other people. It is also true that the final outbreak of schizophrenic disorder will be characterized by regressive tendencies in the direction of this original early period of schizophrenogenic traumatization. One of the means of defense against warp from the outside and hostile reaction against it from within in the pre-schizophrenic as well as in the schizophrenic personality is the withdrawal of interest from the outside world and from other people.

As was pointed out early in psychoanalytic research by Fenichel and Abraham,[4] the withdrawal is not a complete one, nor is the early developmental phase to which the schizophrenic regresses one in which he was "narcissistic" at the exclusion of his relatedness to other people.

Sullivan[5] teaches that there is no developmental period when the human exists outside of the realm of interpersonal relatedness. From the very early postnatal stage, at which time the infant first learns to sense approval and disapproval of the mothering person by empathy, some degree of interpersonal relatedness is maintained throughout life by everyone, regardless of his state of mental health; therefore its disruption in the schizophrenic is only partial.

Fairbairn[6] has offered another significant revision of Freud's concept. Psychoanalytic theory attributes a two-sided significance to the early phases of psychosexual development. The oral and anal preoccupations of the child or of an adult in a regressive state are first understood in terms of the feelings of lust obtainable from these bodily zones and from their functions and, second, in terms of their use for the expression of one's relatedness to significant people. According to Fairbairn, the latter is what counts for the developmental understanding of schizophrenic psychopathology. In his investigation of schizophrenic oral preoccupation from the viewpoint of its interpersonal significance rather than as a source of autoerotic gratification, Fairbairn also made it evident that schizophrenics do not ever totally relinquish their ability to relate themselves to others, even in the most regressive withdrawal states with marked oral preoccupation.

Moreover, the schizophrenic patient has lived and developed personal relationships in his premorbid days—that is prior to being actually disturbed and given to marked withdrawal and regression. Here is an additional reason for the psychoanalyst's always being able to find traces of previous interpersonal developments in the schizophrenic. No matter how tenuous they may be they are sufficient for the establishment of a new relationship, the doctor-patient relationship. This experience has been verified by all those who have done psychoanalytic psychotherapy with schizophrenics. In addition to the above mentioned authors, it has received verification especially by Federn[7] and recently by Rosen.[8]

[3] Freud, "On Narcissism: an Introduction" (1914) in *Collected Papers*, Vol. 4: 30-59: London, Hogarth Press, 1925. See also section on "The Interpretation of Dreams," in *The Basic Writings of Sigmund Freud;* New York, Modern Library, 1938.

[4] Karl Abraham, "Short Study of the Development of the Libido Viewed in the Light of Mental Disorders" (1924) in *Selected Papers of Karl Abraham*, edited by Ernest Jones; London, Hogarth Press, 1927: pp. 418-501.
Otto Fenichel, *Outline of Clinical Psychoanalysis;* New York, W. W. Norton & Co., 1934.

[5] Sullivan, *Conceptions of Modern Psychiatry*, reference footnote 1.

[6] W. R. D. Fairbairn, "Endopsychic Structure Considered in Terms of Object-Relationships," *Internat. J. Psychoanal.* (1944) 25:70-93. "Object-Relationships and Dynamic Structure," *Internat. J. Psychoanal.* (1946) 27:30-37.

[7] Paul Federn, "Principles of Psychotherapy in Latent Schizophrenia," *Amer. J. Psychotherapy* (1947) 1:129-144. Also, see Federn, reference footnote 2.

[8] John N. Rosen, "A Method of Resolving Acute

Several authors—for instance, Hinsie [9] —found, as this writer [10] did, that the schizophrenic's expectancy and tendency toward resuming interpersonal contacts were sometimes equally as strong as his original motivation for withdrawal. This seemingly paradoxical attitude can be easily understood since the schizophrenic has not resigned from interpersonal dealings freely or of his own design but is motivated by dire, defensive necessity. Because of this, he is frequently very willing to break through his self-imposed withdrawal if the analyst has been successful in overcoming the schizophrenic's well-founded suspicions not only of the significant people, because of whose malevolence he originally withdrew, but later of the members of the human race at large, including himself and the psychoanalyst.

It appeared then that it was possible to deal with schizophrenic communication as meaningful and potentially understandable and to establish workable relationships between the psychoanalyst and the schizophrenic. So the road was open to follow the hope and suggestion expressed by Freud in his paper "On Psychotherapy" that analytic technique might be modified for application to the psychotic.[11] This has been done during the two last decades by authors quoted elsewhere in this paper and by Bak, Ernst, Hollos, LaForgue, MacBrunswick, Silverberg [12] and by the psychoanalysts connected with the psychoanalytically oriented mental hospitals.[13]

I had the privilege of reporting upon this work at two previous meetings of the American Psychoanalytic Association. In this paper I wish to describe the changes in technique as they have been developed in the Washington-Baltimore area since my last presentation in 1945. Also I wish to elaborate on the personal problems arising for the psychiatrist who undertakes to do psychoanalytic psychotherapy with disturbed schizophrenics. Before proceeding, I wish to sum up briefly those basic schizophrenic dynamics which have guided the psychoanalysts in developing and changing the psychotherapeutic approach to schizophrenia. The schizophrenic is painfully distrustful and resentful of other people, due to the severe early warp and rejection he encountered in important people of his infancy and childhood, as a rule, mainly in a schizophrenogenic mother. During his early fight for emotional survival, he begins to develop the great interpersonal sensitivity which remains his for the rest of his life. His initial pathogenic experiences are actually, or by virtue of his interpretation, the pattern for a never-ending succession of subsequent similar ones. Finally he transgresses the threshold of endurance. Because of his sensitivity and his never-satisfied lonely need for benevolent contacts, this threshold is all too easily reached. The schizophrenic's partial emotional regression and his withdrawal from the outside world into an autistic private world with its specific thought processes and modes of feeling and expression is motivated by his fear of repetitional rejection, his distrust of others, and equally so by his own retaliative hostility, which he abhors, as well as the deep anxiety promoted by this hatred.

Changes in the technique of psychoanalytic treatment during recent years are in regard to both the establishment of the doctor-patient relationship and the approach to the contents of psychotic communication.

Psychoanalysts used to approach the schizophrenic with the utmost sensitive care and caution. We assumed this to be the only way of making it possible for him to overcome his deep-rooted, suspicious reluctance against reassuming

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Catatonic Excitement," *Psychiatric Quart.* (1946) 20:183-198. "The Treatment of Schizophrenic Psychosis by Direct Analytic Therapy," *Psychiatric Quart.* (1947) 21:3-37, 117-119.

[9] Leland E. Hinsie, "Schizophrenias" in *Psychoanalysis Today*, Sandor Lorand (ed.); New York, International University Press, 1944; pp. 274-286.

[10] Fromm-Reichmann, "Transference Problems in Schizophrenia," *Psychoanalytic Quart.* (1939) 8:412-426.

[11] Freud, "On Psychotherapy," 1904, in *Collected Papers*, Vol. 1:249-263; reference footnote 3.

[12] M. G. Ernst, "A Psychotherapeutic Approach in Schizophrenia," *J. Mental Sci.* (1940) 86:668-674.

J. Hollos, *Hinter der Gelben Mauer* (Buecher Des Werdenden); Bern, Huber.

René LaForgue, "A Contribution to the Study of Schizophrenia," *Internat. J. Psychoanal.* (1936) 18: part 2.

W. V. Silverberg, "The Schizoid Maneuver," PSYCHIATRY (1947) 10:383-393.

Gregory Zilboorg, "Ambulatory Schizophrenias," PSYCHIATRY (1941) 4:149-155.

[13] Chestnut Lodge, Forest Sanitarium, The Haven, The Menninger Clinic, Dr. Boss' Psychoanalytic Hospital, Zurich, Switzerland.

and accepting any personal contacts including those with the psychoanalyst. This was especially true for the initial establishment of the relationship. I have described the work during these years of apprenticeship in my paper, "Transference Problems in Schizophrenics." [14]

I still believe it was ultimately helpful to start out that way. Retrospectively it seems to have been the only way for the psychoanalyst to overcome, first, his anxiety in coping with the schizophrenic's aloofness and, later, his amazement at the possibility of breaking through the schizophrenic's state of withdrawal. It paved the way toward enabling us to convince the patient as well as ourselves and our colleagues of the schizophrenic's and the psychoanalyst's ability to establish workable contacts with one another.

Once a relationship with the patient was established, treatment was continued with as much acceptance, permissiveness and as little rejection as could possibly be administered without damage to the institution and to personnel and other patients. Nothing short of actually destructive or suicidal action was prohibited.

Previously, Sullivan had begun to do most successful and instructive research work along similar lines on his schizophrenic ward at the Sheppard and Enoch Pratt Hospital.[15] Kempf and Hadley did similar work at St. Elizabeths.[16]

Nonprofessional closeness, pretense of personal friendship, and violation of the schizophrenic's fear of closeness with its concomitant fear of his own hostility were of course avoided. Also omitted were such signs of acceptance and permissive gestures which, to sustain or repeat over a prolonged period of time, would go beyond the psychiatrist's endurance. This had to be seriously considered lest what appeared to be therapeutic acceptance would ultimately be reversed into a new case of rejection.

In spite of this background of basic permissiveness, treatment was not just effective by virtue of the "love" offered, as Kurt Eissler [17] has intimated. What has been described here is the interpersonal background, not the contents of the treatment.

The psychoanalysts of this area have subsequently learned that this was not the only nor the best way of establishing an effective interpersonal treatment background. One reason is because this type of doctor-patient relationship addresses itself too much to the rejected child in the schizophrenic and too little to the grown-up person before regressing. Something in every nondeteriorated adult schizophrenic senses at least dimly that his disaster cannot be solved by one person's offering him a type of acceptance otherwise not mutually obtainable in adult society. Therefore the psychoanalyst also should address himself to the patient on the level of his present chronological age. There is the danger that unmitigated acceptance may be experienced by the sensitive adult schizophrenic as condescension or at least as lack of respect on the part of the psychoanalyst. There is the further danger that oversolicitousness in playing up to the patient's sensitivities will be interpreted by the patient as, and may actually be, a sign of anxiety on the part of the therapist. Such anxiety, as well as other countertransference phenomena and the rôle of the therapist's personality in general, need serious consideration in the psychoanalytic work with schizophrenics; they will be discussed in the second part of this paper.

As for the approach to the patient, it holds true for the psychotic as well as for the neurotic that the damage done to him in early life cannot be undone by therapeutically manufactured unlimited acceptance in later life but only by understanding of and insight into the nature of the early trauma.

For all of these reasons, the psychoanalyst learned to change his generalized attitude of permissiveness and acceptance into one of acceptance of and permissiveness toward the regressive infant as part of the patient's personality, blended however with one of respect and understand-

[14] Fromm-Reichmann, reference footnote 10.
[15] Sullivan, reference footnote 2.
[16] E. J. Kempf, *Psychopathology;* St. Louis, C. V. Mosby Co., 1920.
[17] Kurt R. Eissler, "Limitations to the Psychotherapy of Schizophrenia," PSYCHIATRY (1943) 6:381-391.

ing according to the patient's chronological age. This holds true for the initial period of establishing contact and throughout the treatment period.

For example, initial contact with a patient who previously had to be induced to treatment-acceptance by three months of waiting outside his door [18] might now be tried by seeing that patient while he is in a pack or continuous bath until he has overcome the period of violent opposition. The reasons for this procedure should be frankly discussed with him.

After the initial contacts with the patient have led to the establishment of a workable doctor-patient relationship, the attempt is made with the articulate schizophrenic to establish a consensus about the need for treatment and its reasons. The patient will then be guided with the psychoanalyst as participant observer into collaborative efforts at understanding, working through and gaining insight into the genesis and dynamics of his mental disturbance until constructive, lasting, and therapeutically valid insight becomes his. In other words, the goal of treatment is the same as it is with neurotics. The method is different until manifest psychotic symptomatology has disappeared.

The investigation of the doctor-patient relationship and its distortions will be included in the therapeutic process. I do not agree with Abraham and Federn [19] who suggest the animation of positive transference phenomena with the schizophrenic and that one refrains from analyzing them. Those elements of the schizophrenic's relationship with the psychoanalyst the transference character of which is obvious should be used for analytic clarification. Only those elements which are an expression of the real, positive interrelatedness between patient and analyst need not be touched by the psychoanalyst. Sooner or later the articulate schizophrenic will take care of their discussion by himself.

The psychoanalytic knowledge of the potential meaningfulness of most schizophrenic productions plays an important rôle as presupposition for a therapeutically valid interpersonal exchange between patient and analyst. However, in recent years the actual rôle of the therapeutic use of the contents of the schizophrenic's manifestations has undergone considerable change. Formerly the greatest possible attention was paid to the contents per se of all the psychotic's utterances be they ever so bizarre, cryptic, and, at times, seemingly unintelligible.

If the analyst understood the content of the patient's communications, he evidenced his understanding by his responses and further questions. Such mutual agreement on the understanding of content was designed to help break through the self-imposed isolation of the patient in his private world. It was also considered an aid in creating a desirable background for collaborative therapeutic endeavor. However, the analyst would not try to "interpret" content.[20] Interpretation in psychoanalytic terminology means to translate the manifestations of that which is barred from awareness into the language of consciousness. That is what the psychoanalyst has to do for the neurotic in order to help him to become aware of and to understand repressed thought and feeling.

The schizophrenic's problem is not as much that thought or feeling is barred from awareness, but that he is swamped by, from the observer's viewpoint, unconscious material which breaks through the barriers of dissociation. The neurotic and the healthy person have succeeded in keeping this material dissociated. Most of the time this material is within the schizophrenic's awareness. He knows the meaning of his psychotic productions as far as their contents are concerned. It was the psychoanalyst's knowledge of the schizophrenic's awareness of the meaning of his communications which made it seem inadvisable, if not most of the time redundant, to interpret the contents of his productions. I did not refrain from doing so "for the purpose of promoting a type of introjection of the analyst as a good object, which avoided a splitting of

[18] Fromm-Reichmann, reference footnote 10.
[19] Federn, reference footnote 7.
[20] Fromm-Reichmann, reference footnotes 2 and 10.

the ego," as Sylvia Payne suggested in her paper on "Theory and Practice of Psychoanalytic Technique." [21]

This does not mean that I would advocate exclusion of formulations of vague, indirect schizophrenic communications. They frequently become therapeutically more meaningful to the patient as he hears them clearly and directly reformulated in the rational language of the therapist.

As far as actual interpretive help goes, it is needed by the schizophrenic when it promotes understanding of and insight into the *genetics* and *dynamics* of his disturbance. Grotjahn has recently stressed the same point.[22] The analyst has, of course, continued to pay attention to the contents of the schizophrenic's communications so that the analyst may know, if possible, what the patient wishes to convey but its therapeutic importance is no longer overestimated. The importance of the psychoanalyst's misunderstanding and misinterpretation of the schizophrenic's production has also been overestimated. The patient's therapeutic contact with the analyst and his progress, by and large, will not be interfered with by a miscarriage in understanding on the part of the psychoanalyst, if it happens in the spirit of therapeutic humility and not in the spirit of any type of overbearing, personal therapeutic ambition. Lack of spontaneity or over-caution may be more detrimental than faulty directness as long as the latter is serious and sincere in purpose. Clear directness is a necessary device in dealing with disturbed schizophrenics. Their one-track thought processes, lack of reality testing and foresight make it greatly desirable for the psychoanalyst to offer his therapeutic suggestions in terms of one-sided, meaningful, concrete, concise questions and statements. Questioning in terms of "either/or" tends to be confusing, therefore anxiety-producing to the insecure, indecisive schizophrenic.

John Rosen has recently re-established the therapeutic use of interpretation of the content of schizophrenic manifestations in a new setting.[23] I hope that the evaluation of Rosen's material will help to understand the reasons for the therapeutic moves in opposite directions.

Some analysts have misevaluated the significance of the meaningfulness of schizophrenic communications by operating on the faulty conclusion that they can argue on a rational level with the patient about the rationality of his communications and that they can, for example, try to "talk" the patient "out" of a delusional system.

While this obviously does not work, another similar approach has proved to be therapeutically valid. That method is to respond, for example, to hallucinatory or delusional manifestations in terms of registering disagreement, without, however, arguing about them—for instance, by stating, "I do not hear or see what you hear or see. Let us investigate the reasons for the difference in our experience." The analyst may react similarly to psychotic behavior by remarking: "Your hair-pulling, spitting, and so on, does not convey any meaning to me. Maybe you can verbalize what you want to convey rather than act it out."

Incidentally, discouraging irrational behavior by professing lack of understanding of its meaning is not tantamount to advising in principle to "cut it out" the way the analyst does in his dealings with a neurotic. At times "acting out" is the only way of communicating available to the inarticulate schizophrenic.[24] The *irrationality* of his "acts" should then be approached therapeutically. The acting out, per se, has to be accepted until it yields to therapeutic efforts and is replaced by the patient's regained ability of using verbalized communication.

Only in cases where sustained efforts to reach the patient on a verbalized rational level have consistently proved to be unsuccessful over a period of time has it seemed necessary to temporarily enter into the schizophrenic's psychotic world. In such cases the analyst participates for

[21] Sylvia M. Payne, "Notes on Developments in the Theory and Practice of Psychoanalytical Technique," *Internat. J. Psychoanal.* (1946) 27:12-19.

[22] Martin Grotjahn, "Emotional Reeducation in Supportive Therapy," in *Psychoanalytic Therapy*, Franz Alexander and T. M. French; New York, The Ronald Press Co., 1946; pp. 165-172.

[23] Rosen, reference footnote 8.

[24] Fromm-Reichmann, reference footnote 2.

the time being in the patient's delusional experiences until he gets ready to investigate their dynamics with the psychoanalyst.

Here again our present method in this area differs from Rosen's and we hope to get an answer to the validity of both approaches upon future investigation.

Now, as to the changes tried in this area after the therapeutic approach in terms of overemphasis of contents was discarded. Mainly promoted by Sullivan,[25] it was replaced in recent years by developing a technique of focusing therapeutic attention upon the genesis and dynamics which determine the contents of the schizophrenic production. As a way of accomplishing this, close attention is paid to, and careful investigation done about the following: present timing and circumstances, the original setting, precipitating factors and bodily and emotional symptoms preceding or concomitant to a psychotic manifestation. The patient is trained if he is in contact to join the psychoanalyst in his endeavor to find those connections. We have been gratified by the disappearance of psychotic manifestations subsequent to their consistent, repetitive, generic, and dynamic scrutiny. Once accepted by the introspectively gifted schizophrenic, this procedure leads automatically toward the investigation and understanding of neighboring symptomatology which has been linked up with the manifestations originally under scrutiny. Staveren has given an illustrative example of this technique in his paper on "Suggested Specificity of Certain Dynamisms in a Case of Schizophrenia."[26] For other illustrative examples of the above described method see Tower and Cohen.[27]

In cases where the patient is too disturbed to participate actively in this generic and dynamic scrutiny it still has proved ultimately helpful if the analyst directs his therapeutic attention in this direction and tries to communicate this effort to the patient until such time when the patient emerges sufficiently from his psychotic state to follow suit.

There has been much discussion about the timing of the analyst's active therapeutic endeavor with the schizophrenic. In my opinion, much valuable time has been lost by waiting too cautiously until the patient was "ready" to accept one or another active therapeutic intervention. Once a workable doctor-patient relationship has been established, the patient is "ready" to be approached with active therapeutic moves. The fact that he may not be able to accept them immediately is not necessarily a sign of the approach being counterindicated. It may have to be repeated and "worked through" innumerable times but that is no reason not to get started.

There are only two reasons for being cautious in one's timing of active therapeutic moves. One reason is the slowed down and narrowed concrete thought-processes of many schizophrenics. These make it necessary to offer only one therapeutic suggestion at a time and not to offer a second one before there is evidence that the first one has been heard, even though not yet necessarily worked through and integrated.

The second reason is the schizophrenic's anxiety and tendency to go into panic. Therapeutic moves which are liable to produce manifest anxiety have to be offered in such dosage that anxiety does not turn into panic. Also they should be offered at a time when the psychoanalyst will be available if needed to help the patient cope with his anxiety.

In recent years, Sullivan has succeeded in giving more specific direction and content to the therapeutic scrutiny of the schizophrenic's communications and symptomatology. According to him the psychodynamics of mental illness including the schizophrenic manifestations can be understood as a result and an expres-

[25] Sullivan, reference footnote 10. See also Sullivan, "Therapeutic Investigations in Schizophrenia," PSYCHIATRY (1947) 10:121-125. "Notes on Investigation, Therapy, and Education in Psychiatry and Their Relations to Schizophrenia," PSYCHIATRY (1947) 10:271-280. "The Meaning of Anxiety in Psychiatry and in Life," PSYCHIATRY (1948) 11:1-13.

[26] Herbert Staveren, "Suggested Specificity of Certain Dynamisms in a Case of Schizophrenia," PSYCHIATRY (1947) 10:127-135.

[27] Robert A. Cohen, "The Management of Anxiety in a Case of Paranoid Schizophrenia," PSYCHIATRY (1947) 10:143-157.

Sarah S. Tower, "Management of Paranoid Trends in Treatment of a Post-Psychotic Obsessional Condition," PSYCHIATRY (1947) 10:137-141.

sion of unbearable anxiety and, at the same time, as an attempt at warding off this anxiety and keeping it from awareness. Full-fledged anxiety is to be considered the most discomforting and disconcerting experience to which a person can be subjected. Remembering this, the analyst will not be surprised to find that the most bizarre and, as to contents per se, unintelligible, irrational, time-thought- and energy-consuming communications and symptoms may be used as security-operations in the presence of threatening anxiety.[28]

"Anxiety," in Sullivan's definition, is the discomfort which the child learns to feel in the presence of the disapproval of the significant adult who first uses the arousal of this discomfort as a tool while training the child to abide by the basic requirements of acculturation. With great variations as to the ultimate threshold of endurance, anxiety remains effective throughout people's lives in response to disapproval from important people which interferes with a person's security and prestige.[29]

In Freud's later formulation, as given in *The Problem of Anxiety,* anxiety is the fear of the dangers which threaten people from within, that is, regarding their culturally inacceptable inner strivings.[30]

I will not enter into a discussion of the variations in concepts of anxiety offered by other authors such as Goldstein [31] and Horney [32] but refer to it in terms of the above given definitions.

The therapeutic validity of a consistent dynamic approach to schizophrenic symptomatology as a manifestation of the patient's underlying anxiety and his operational efforts to evade its rise and awareness has proved to be most useful and effective with many schizophrenics.

Other suggestions as to set-up and technique in psychoanalytic work with schizophrenics are still valid as previously given.[33] The classical set-up of the psychoanalyst sitting behind the patient who lies on the couch is counter-indicated. This arrangement interferes with the re-establishment of the patient's ability of reality-testing and of the psychoanalyst's use of visual observations which are especially helpful in the case of inarticulate schizophrenics.

Equally counter-indicated are rigidly scheduled one-hour interviews. Flexible schedules which allow for either cancellation of sessions, sessions of several hours, or non-scheduled extra interviews are indispensable in psychoanalytic work with disturbed psychotics.

Unlike Schilder [34] and Glover,[35] I recommend with Sullivan,[36] Weininger,[37] and Rosen [38] that the schizophrenic be seen by the analyst through all prolonged states of psychotic disturbance regardless of the visible and immediate gain of insight from interviews during such periods. Usually one sees later on that there has been some gain in insight, even though it could not be acknowledged or verbalized at the time. Also, the maintenance of therapeutic contact through periods of disturbance is useful for the sake of later therapeutic reference. Incidentally, my experience with reviewing these disturbed periods with the patient following his recovery has also been a gratifying one—in contrast to some other therapists who warn against it.[39]

The use of the technique of free association constitutes a definite mistake in psychoanalytic therapy with schizophrenics. The thinking and expression of the disturbed schizophrenic is frequently disorganized or in danger of dis-

[28] Sullivan, reference footnotes 5 and 25.
[29] Sullivan, reference footnote 5.
[30] Freud, *The Problem of Anxiety;* New York, W. W. Norton & Co., 1936.
[31] Kurt Goldstein, *Human Nature in the Light of Psychopathology;* Cambridge, Harvard Univ. Press, 1940.
[32] Karen Horney, *The Neurotic Personality of Our Time;* New York, W. W. Norton & Co. 1937. *New Ways in Psychoanalysis;* New York, W. W. Norton & Co., 1939.
[33] Fromm-Reichmann, reference footnotes 2 and 10. See also "A Preliminary Note on the Emotional Significance of Stereotypies in Schizophrenics," *Bull. Forest Sanitarium,* 1:17-21. "Problems of Therapeutic Management in a Psychoanalytic Hospital," *Psychoanalytic Quart.* (1947) 16:325-356.
[34] Paul Schilder, *Psychotherapy;* New York, W. W. Norton & Co., 1938.
[35] Edward Glover and Marjorie Brierley, *An Investigation of the Technique of Psychoanalysis;* London, Ballière, Tindall & Cox, 1940.
[36] Sullivan, reference footnotes 1, 2, and 5.
[37] Benjamin I. Weininger, "Psychotherapy During Convalescence from Psychosis," PSYCHIATRY (1938) 1:257-264.
[38] Rosen, reference footnote 8.
[39] Fromm-Reichmann, reference footnotes 2, 10, 33.

organization. The psychoanalyst certainly does not wish to increase the loosening up and disorganization of psychotic thought and expression by the artefact of free associations for alleged therapeutic purposes. The only time when the analyst may ask the psychotic to express himself in terms of associative thinking will be in regard to a specific problem, its origin and timing, and so on, if direct questioning does not lead to the desired results.

In this connection the problem of dream interpretation with schizophrenics should be discussed. Because of the above-mentioned similarity between the dynamics of thought processes in dreams and schizophrenic thought processes in awakened states, psychoanalysts used to consider it counter-indicated to work on dreams with schizophrenics and we discouraged the recital of dreams. In recent times, however, three treatment histories of paranoid schizophrenics were brought to my knowledge (Drs. M. Spottswood, J. Hartz, and T. Lidz in Baltimore) which encouraged reconsideration of our viewpoint. Each of the patients anticipated in a significant dream marked improvement which he subsequently accomplished upon recital and collaborative interpretation of the dream with the psychoanalyst.

While the analyst does not wish to induce associative thinking but prefers to direct the patient's productions, he must keep in mind that there are many schizophrenics whose verbalized productions are so scarce that he cannot direct their communications. Then he must use what productions he can obtain for meaningful therapeutic work regardless of the seeming remoteness of such communications from the immediate therapeutic aim he plans to pursue. If the analyst is sufficiently flexible, he will be able to use in his therapeutic plan, sooner or later, any manifestation which he elicits from an inarticulate patient.

This approach is somewhat similar to play technique with children. It will be well in this context to keep Federn's remark in mind: "When we treat a schizophrenic, we treat several children of different ages." [40] Yet the truth of the matter is, as mentioned before, that the psychoanalyst, as he works with a disturbed schizophrenic, is not only treating a child at different ages but also, and at the same time, an adult person of the chronological age at which he comes into treatment. This is one of the main reasons for the difficulties in psychoanalytic work with schizophrenics. All analysts, in their dealings with schizophrenics, seem to struggle with it as they try to develop the technique of treatment most suitable to their own and to the patients' personalities. Psychiatrists who are not sufficiently flexible may find it difficult to address themselves simultaneously to both sides of the schizophrenic personality. They may behave like rigid parents who refuse to realize that their children have grown up. The undesirable results of the psychiatrist's reluctance to communicate with the adult part in the patient's personality and his addressing himself only to the regressive parts in the patient have been discussed before.

If, on the other hand, the psychotherapist addresses himself to the adult patient only, out of an erroneous identification with the patient, he renounces comprehension of and alertness to crucial parts of the schizophrenic psychopathology.

The intricacies in the handling of this situation point toward the discussion of the rôle that the personality of the therapist plays in the treatment of schizophrenics.

The results of the psychotherapeutic endeavors with disturbed schizophrenics, so far, are not too discouraging. However, cures have not been to the psychoanalysts' satisfaction as to number or durability. Some of the failures are not because of the therapeutic technique used but because of personal problems of the psychotherapist in his dealings with schizophrenics and because of the personality of the therapist.

Every psychotherapist, and especially one who works with schizophrenics, should be clear about his rôle in the psychotherapeutic process. He should know that he is not called upon to fulfill any noble, magic mission. More skeptical of

[40] Federn, reference footnote 7.

all types of would-be and as-if attitudes than the rest of us, the schizophrenic will definitely react unfavorably to a therapist with alleged missionary and similar God-like attitudes. They are usually designed to make the therapist feel good as a self-inflationary measure, but they fail to make the therapist alert to the patient's needs and they certainly fail to impress the schizophrenic.

The job of the psychotherapist is to be the participating observer in the interpersonal process between himself and the psychiatric patient. He must know how to listen and how to elicit the data from the patient. By these means he can guide the patient toward the therapeutically valid generic and dynamic understanding of and the insight into his illness, which is the goal of psychoanalytic psychotherapy.

In the course of this process, and without becoming involved himself, the psychotherapist must be able to allow the patient to repeat and, by doing so, to resolve old pathogenic interpersonal patterns with him as a person and as a distorted shadow of other important people of the patient's previous life.

One more reason for the specific difficulty in doing psychotherapy with the schizophrenic springs from the schizophrenic's aloofness. The active, eager psychotherapist is liable to interpret this general aloofness which long antedates the patient's contact with the psychiatrist as a sign of personal resistance directed against him. He may be liable then to allow himself to be hurt or paralyzed by the patient's state of withdrawal.

Another feature of schizophrenic psychopathology which seems to be taxing to many psychiatrists is that many schizophrenic communications, while meaningful to the patient, will not be intelligible to the therapist. Many psychiatrists find it difficult to accept the fact that they, supposedly being of sound mind, cannot make out what the disturbed schizophrenic, who is allegedly "out of his mind," communicates and understands. This experience threatens some psychiatrists' security and it arouses the resentment of others against the patient by whom they feel humiliated. Either outcome will interfere with the doctor's therapeutic usefulness.

A fourth personal difficulty springs from the resentment and at times rage or fury harbored by the schizophrenic in response to his early traumatic experiences and of which the patient himself is afraid. Without any artificial encouragement every schizophrenic will, at times, give vent to this hostility in front of the therapist, thus learning to face and to integrate it, or to overcome part of it. I do not believe, as many classical psychoanalysts do, that man is born to be hostile. However, the personal hostility which is engendered by the early pathogenic warp, rejection, and malevolence he has encountered is among the serious psychopathological problems of the schizophrenic. Nevertheless encouragement of hostile expression in the schizophrenic for alleged therapeutic purposes is not to be advocated. Nor should the psychiatrist expose himself to hostile action or violence on the part of the patient. Schizophrenic violence is seldom malevolent but it should not be endured by the psychiatrist with the erroneous rationalization of therapeutic heroism. Avoidance, if possible, is not only recommended for reasons of the doctor's self-protection but also to protect the patient's self-respect. In retrospect, recall of violence constitutes a serious blow to the self-respect of many schizophrenics.

Each time the psychiatrist undertakes one of the therapeutically important frontal attacks against the schizophrenic's defenses in his avoidance of the rise and awareness of anxiety he ought to make sure that his own state of mind is one of stability and serenity. Otherwise his own counter-hostility, fear, or anxiety may blind him in the therapeutic evaluation of the patient's experience. Also, they will, in turn, make the patient more hostile and anxious. The psychiatrist's anxiety is a threat to the insecure schizophrenic and it causes an empathic increase in his anxiety. It is a measuring rod for the degree of disapproval and rejection which the patient expects from his fellow men for the anxiety-provoking,

negative impulses which he suffers and which he, himself, abhors.[41]

Another possible unfortunate outcome of the therapist's anxiety is his need to give uncalled-for reassurance to the anxious schizophrenic, thus killing the patient's attempts at bringing his anxiety into the open and in verbalizing it. Constructive reassurance is encouraging the patient to express and face adequate amounts of hostility and anxiety and their causes. Attempts at mitigation by patting the patient on the back, as it were, are discouraging. The patient senses the therapist's own anxiety or lack of understanding which underlies such a non-therapeutic performance. For all of these reasons it should be evident that it will constitute a serious handicap to ultimately successful therapy if the schizophrenic succeeds in evoking the psychiatrist's anxiety.

The schizophrenic's ability to eavesdrop, as it were, on the doctor creates another special personal problem for some psychiatrists. The schizophrenic, since his childhood days, has been suspiciously aware of the fact that words are used not only to convey but also to veil actual communications. Consequently, he has learned to gather information about people in general, therefore also about the psychiatrist, from his inadvertent communications through changes in gesture, attitude and posture, inflections of voice or expressive movements. Observation of all these intangibles is one way of survival for the anxious schizophrenic in the presence of threatening malevolent interpersonal performances which he is always expecting. Therefore the schizophrenic may sense and comment upon some of the psychotherapist's assets and, what is more frightening, his liabilities, which had been beyond the limit of the psychiatrist's own realization prior to his contact with the schizophrenic patient. An insecure psychiatrist will be made anxious by being exposed to the schizophrenic's empathic ability for this type of eavesdropping and so become preoccupied with his own defenses.

Perhaps the greatest threat to a favorable outcome of psychotherapy with schizophrenics, which is directly attributable to the therapist, is the conventional attitude of many psychotherapists toward the question of the so-called social adjustment of their schizophrenic patients. The recovery of many schizophrenics depends upon the psychotherapist's freedom from conventional attitudes and prejudices. These patients cannot, and should not be asked to, accept guidance toward a conventional adjustment to the customary requirements of our culture, much less to what the individual therapist personally considers these requirements. The therapist should feel that his rôle in treating schizophrenics is accomplished if these people are able to find for themselves, without injury to their neighbors, their own sources of satisfaction and security, irrespective of the approval of their neighbors, of their families, and of public opinion. This attitude is required because, as a rule, a schizophrenic's recovery will not include the change of his premorbid schizoid personality to another personality type. Schizophrenia, in this sense, is not an illness but a specific state of personality with its own ways of living.[42]

I am convinced that many schizophrenics who remain ill could recover if the goal of treatment were seen in the light of the needs of a schizoid personality, not according to the needs of the non-schizophrenic, conforming, good-citizen-psychiatrist.

In conclusion, I wish to recommend that the therapist be trained in recognizing and controlling his own dissociated feelings and motivations and in overcoming his own insecurity, previous to working with schizophrenic patients. Many failures in the treatment of schizophrenics, due to the therapist's failure in handling his and the patient's mutual interpersonal problems adequately, could then be avoided.

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[41] Fromm-Reichmann, reference footnotes 2, 10, 33.

[42] Fromm-Reichmann, reference footnote 2. Sullivan, reference footnotes 1 and 25.