The Therapist's Personality in the Therapy of Schizophrenics

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As our knowledge of psychotherapy with schizophrenics increases, it becomes more apparent that the attitude and reactions of the therapist are of much greater importance in the treatment situation than is the case with neurotics. It seemed to me important to outline the kinds of difficulties therapists are apt to encounter in doing intensive psychotherapy with psychotics, and, if possible, to determine what attitudes in the therapist are most likely to engender or foster technical problems in therapy. It is important to stress that this is an impressionistic and biased account of the problem.

Most therapists who work with schizophrenics seem to experience intense anxiety at times. If the therapist can accept this and can understand its origin, he may not be too threatened when his uneasiness is apparent to the patient, his colleagues, or other staff members. If it is recognized that one can be an adequate therapist without being uniformly serene, then the therapist may allow himself to get close to the patient without the vertical distance so often necessary for the maintenance of prestige. It seems unlikely that one can treat a disturbed schizophrenic without suffering certain "indignities," such as being ridiculed, scorned, ignored, disarranged, or assaulted. These are not actions one has been led to believe should happen to a physician, and the status hierarchy of the mental hospital does not make the problem any easier.

Submitted for publication March 28, 1955.

Presented at the Annual Meeting of the American Psychiatric Association, Los Angeles, May 7, 1953.

Early in my work with schizophrenics, it was usual to feel humiliated as I passed the nurses' station after interviews with disturbed patients. Occasionally, my clothing would be somewhat disarrayed and the patient would be screaming curses at me as I walked down the hall. I imagined that the nurses were laughing at the sorry spectacle that I presented, and I often tried to cover up my humiliation by telling wonderfully rich tales about the patient's progress in therapy.

Some of the anxiety which any therapist experiences with psychotics seems to arise from the peculiar problem in communication which such patients pose. The difficulty in understanding what the patient is saying may produce helplessness and resentment in the therapist, and he may be further dismayed by doubt as to the best method of intervention. Should he be silent, make a "direct" interpretation, or concentrate on body language?* There are the elements of a vicious cycle present, and nowhere is it more apparent than in the problem of handling prolonged silences. The patient's silence becomes more of a personal rebuke as the therapist's helplessnness increases, and the therapist is apt to respond with punishing phrases that are draped in a thin veil of, "for your own good," to which the patient responds with a more prolonged silence. On a number of occasions therapy is broken off at this point, perhaps by the therapist thinking in terms of shock therapy or lobotomy or by emphasizing the patient's social participation in the hospital.

Another difficulty peculiar to this kind of therapy is the schizophrenic's ability to pick up nonverbal cues as to what is going on in

* References 1 to 3.

other people. The patient may notice evidence of anxiety which the therapist unwittingly has tried to hide. This ability of the schizophrenic arises, of course, from his early experience with significant others. Because he feels as though he has been living in a hostile jungle, he has learned to develop certain methods for handling potential danger; one of these methods is to understand that people do not always mean what they say, and he learns to examine carefully any kind of cues that the environment offers. This ability, while quite real, may have exaggerated manifestations, as when the patient distorts a nonharmful situation into a harmful one. The therapist beginning work with a schizophrenic may be inclined to be overly impressed with the "mind reading" ability of the patient and overlook the mistakes in evaluation of other people that the schizophrenic makes because of lack of awareness of his own feelings and lack of experience in living.

For example, a beginning therapist was much impressed with the fact that a schizophrenic woman patient detected hostility in a third person which the therapist had completely missed until the patient called it to his attention. He later discovered that the patient also detected what she believed to be hostility when no confirmation could be found for it and when the patient had no evidence to support her observation. He realized in this situation that she was angry herself, but unaware of it.

While the therapist must be alert to the patient's tendency to confuse his inner feelings with what he finds in the environment, he must at the same time be accepting of the validity of the patient's experiences as they are related. Otherwise, the therapist may fail to pay enough attention to the patient's actual experiences and convey the idea that all feelings and impressions are "projections." Once the therapist evinces skepticism, the patient tends to omit any confirmatory or explanatory data, confirming, in turn, the therapist in his suspicion that this is a distortion of some sort. The reality of the patient's situation must be discussed first before the therapist attempts to find out how much the patient's past experience is coloring the present, or the patient may cease his attempt to communicate effectively.

A particularly troublesome situation may arise in the treatment of schizophrenics who are partially masking their psychotic difficulties by hysterical symptoms, which include a tendency to dramatize. The therapist may be tempted to intervene by cracking down on the patient and may be unusually alert to the possibility of the patient's exploiting him. The patient's inability to face the tragedy of his illness is furthered by the therapist's attitude, since they both, in effect, focus on the patient's demands or unreasonableness and neglect his difficulty in communicating his underlying loneliness and despair. The therapist who sees the patient in the present and in the past at the same time is not apt to respond only to present symptoms or to overlook the reality of the person who is currently living in an unhappy situation. Similarly, the accepting therapist seems most frequently to interpret dependency before hostility. He realizes that the patient's acceptance of his dependent needs strengthens the therapeutic relationship and allows hostile feelings to emerge with less fearfulness and guilt on the patient's part.

The ability to keep in mind the child but not neglect the adult is of help also as the transference becomes intense. In psychiatric supervisory work one may note at some point in the case being presented that the therapist is responding to a picture the patient has of him, and that the therapist has given the supervisor many cues about this situation, although unaware of it himself. It is as though the patient's transference is perceived unconsciously by the therapist as a *Gestalt*, to which he then reacts before he has consciously assembled the pieces of the puzzle. As the patient describes this picture of the therapist, the therapist may experience uneasiness lest this unflattering picture corresponds too closely to his character; and he may, in effect, then tell the patient to "stop feeling that way."

For example, a schizophrenic woman was able to make her male therapist anxious by her demands and by behaving as if she couldn't live without him.

an integration which she had learned early in her childhood. Unfortunately, the therapist had had so much experience with somewhat similar women in his own life that he saw himself as the patient did. He began to confuse the patient, his wife, and his mother in his dreams and tried to be firm toward the patient and to convince her that she was not a weak twig. The treatment situation began to degenerate still further when the patient accused the psychiatrist of hating her, as her husband obviously did; the therapist could confirm her suspicions all too well in his contemplative hours away from the patient. This awkward situation began to be resolved when the therapist, through supervision and his own therapy, began to realize that there was a great deal of difference, in degree at least, between the patient's transference picture of him and his own picture of himself. He saw, more specifically, that the patient's demanding ways arose because of her own extreme inability to tolerate any anxiety whatsoever and that she used involvement with other people as a defense.

Other difficulties in communication may arise from the therapist's need to assure himself and the patient that he is not afraid or anxious. He may develop the habit of staring at the patient as if to demonstrate a lack of uneasiness and may succeed in making the shy patient quite uncomfortable. Another forceful technique is the attempt to "pin the patient down." This consists in asking questions in a district attorney fashion, so that "one gets clear on something," or to demonstrate the patient's lack of contact with reality. The questions are often handled by the patient with a "yes" or "no" answer, and the amount of information garnered starts as a trickle and rapidly diminishes to drops. If an open-ended question can be phrased in a fashion that does not require a humiliating answer, the subject under discussion may be expanded by the patient. The manner of asking questions and clues as to their phrasing depend to some extent on the realization that the patient may not be just resistant or negativistic but may be protective of hiatuses in his own life experience. The lack of chum relationships and the opportunity to validate consensually his experience in living with another person [4] imply that the schizophrenic has little knowledge of the relief and joy that come through sharing experiences. He may not be able to mention certain of his feelings to the therapist because he believes that they are unique, or he may not respond in the usual fashion to certain questions because he senses something has been missing in his experience and is humiliated about exposing himself to a stranger—physician or not!

One area in particular where questioning can lead to intense humiliation is in asking (especially male) patients about their sexual experiences. It is sometimes obvious in the technique of young psychiatrists that they are hell-bent on exposing the patient's homosexuality, as a surgeon might excise and drain a pus pocket. This sometimes leads to outbursts of alleged sexual activity toward nurses and occupational therapists as the patient attempts to become the man his psychiatrist does not seem to feel he is. It is helpful if the therapist is able to note flushing, sweating, bodily movements, respiratory changes, etc., as he asks questions, so that he has some information about the effect he is producing.† Thus, a therapist noted that a patient's foot jumped while mentioning a person's name during the course of describing an episode in an apparently unanxious fashion. Some months later, the therapist was able to get the patient to clarify his homosexual relationship to this person, and the patient commented with relief that it was the first time he had ever discussed this with anyone.

Many of the difficulties mentioned thus far are virtually impossible for young therapists to correct without adequate supervision. It may occur in the therapy of neurotics that the patient on occasion will set the therapist

† A fairly successful way in which to demonstrate observational and questioning techniques is for the supervisor to interview a schizophrenic patient that is not known by himself or the residents, and to see how much can be learned about this person's life and difficulties on the basis of a 30- or 40-minute interview. The number of correct guesses (when subsequently checked against the patient's history) is often a graphic demonstration of the manner in which cues of all sorts are used in an interview situation; and the blind alleys are also fruitful topics for discussion.

straight; but, unfortunately, with very ill psychotics a serious mistake may herald the beginning of the end for this particular relationship. In addition, adroit supervision [5] may render the therapist less anxious and allow him greater freedom to use his resources. A small piece of work done in a supervisory session that pays off in a therapy hour may act as a catalyst for a whole chain of helpful interactions.

A young male schizophrenic had particularly strong competitive feelings about his brother and felt hopeless to do anything about them—particularly in the area of his brother's athletic prowess. One day the patient mentioned to his therapist his newly found pleasure in playing volley ball; and, although the therapist had actively encouraged the patient to participate in daily activities at the hospital, he did not specifically show his interest when the patient mentioned this new activity. The supervisor noted the oversight to the therapist and suggested that he mention his interest to the patient at an appropriate time and acknowledge the oversight. Two weeks later the therapist had occasion to mention the incident, and the patient became obviously pleased and excited. He walked over toward the therapist, asked for a light for his cigarette, and spoke rapidly and coherently about his need for help and his recognition of the difficulty he had had in learning to trust the therapist and to rely on him for help.

There are tremendous opportunities for learning for the inexperienced therapist if he works with a disturbed psychotic under adequate supervision. For one thing, young therapists in this situation seem to become remarkably interested in the effect of their own personality on the total treatment situation and in supervisory sessions will often bring up the subject for discussion without any prompting. Perhaps the lack of fixed techniques in treating schizophrenics offers the therapist better opportunity to become acquainted with himself; and the intensity of feeling and sensitivity to the therapist that the patient so commonly manifests acts as an additional aid toward the therapist's self-awareness. Another aspect of the opportunity offered by this kind of therapy is that the young therapist does not feel that the failure of a therapeutic venture with a schizophrenic carries as much loss of prestige as though it had happened with a neurotic; and he is freer to experiment with various techniques without risk to his prestige, and with less chance of feeling that he is running counter to the wishes of his superiors. Because of our relative ignorance about the therapy of psychotics, the beginning therapist has fewer signposts, rules, and dicta to follow than in treatment with neurotics, where a great many working principles have already been established.

Some tyro therapists, while not planning to devote themselves to therapy with psychotics, seize upon the opportunity to gain experience in this arena of intense emotion as a preparation for their subsequent psychotherapy with neurotics. It is not uncommon to hear a supervisee state that such and such a problem with a neurotic patient has been clarified without help after a more intense experience with a psychotic has been worked through. An example that comes to mind is that of a young therapist who appropriately raised the fee of a private neurotic patient after he had successfully handled his fear of assault from a psychotic in the hospital.

Given a group of inexperienced psychotherapists undertaking work with psychotics, I feel it is often the case that they can be loosely divided into groups that have in common certain prevailing attitudes toward the patient. These attitudes (roles, sets) usually can be seen in every one of the therapists, but certain of them manifest enduring patterns of interaction with the psychotic patients that tend to distinguish them from the other therapists. It may be helpful, though potentially misleading, to categorize the therapists on the basis of predominant patterns of interaction, if only to alert the supervisor to the special needs and problems of each group.

One group might be labeled those therapists with an intellectually competitive attitude. A rather large number of psychotherapists who become interested in undertaking intensive psychotherapy with psychotics are overly intellectually curious and competitive. They tend to be tremendously engrossed in

the productions of the patient and to ignore, to some extent, what is happening between themselves and the patient.

One therapist who was particularly fascinated by the content of the productions of his very disturbed patient encouraged his patient to free-associate. During one hour with this patient, the therapist made an interpretation involving some guesses about the meaning of the patient's masturbation, which topic the therapist had introduced. The patient greeted him at the beginning of the next hour by stating that he wanted to get out of the hospital and to find a job. The therapist and the patient then got into a long discussion about various job possibilities, with the psychiatrist pointing out that the patient should not feel shiftless "because it takes all kinds of people to make a world." The therapist missed the rather obvious connection between the patient's wanting to leave the hospital —and the therapist—and the possibility of the patient's resentment about the interpretation given in the previous session.

It is not unusual for a therapist of this type to be rather fearful of women and unconsciously hostile toward them, an attitude which may result in his developing an erotic attachment to female schizophrenic patients, partly because such a woman is much less threatening than other women that the therapist has known. The patient and therapist may, in effect, relive their adolescence together. Out of this may result a transference jam, with the patient becoming quite disturbed and breaking off treatment. Sometimes the therapist's preoccupation with content is for the purpose of garnering proof of a psychoanalytic doctrine to demonstrate his intellectual capacities and to please his supervisor. This kind of integration with schizophrenic patients is not conducive to adequate communication and may injure the relationship. If the patient reports a pain in his left eye, and the therapist is lost in reflections about sinister and dexter, about one eye seeing evil and the other good, about the eye as an orifice and the proximity of the eye to the brain, he may completely overlook the fact that the patient has made a meaningful gesture which the therapist has missed, being lost in speculation. Such ruminations, while potentially illuminating, may be less important than the interpersonal situation.

A second type of therapist may be one who has an interpretative method for handling all data from the patient. He attempts to resolve the patient's psychosis by "active" interpretations, and perhaps by attempts at camaraderie. Although sometimes the enthusiasm of the therapist may give good results in the initial stages of therapy, this period is typically followed by a lull or actual impasse in the treatment situation. Such a lull or impasse may result in part in the patient's being disappointed in the therapist's failure to live up to his initial promise; or the therapist may be ignoring the primary processes and treating the patient as if he operated at a more integrated level than he is capable of; or the difficulty may stem from strong sexual feelings which develop toward the therapist and are not noticed, or, perhaps most importantly, the interest in symbolization may result in the therapist's overlooking the simple human feelings that the schizophrenic manifests toward someone who is taking an interest in him. It is perhaps a cogent point that the "dynamic" therapist, if inexperienced, will interpret dynamically those facets of the relationship that impinge upon his own awareness and are not necessarily the most currently relevant. A strong statement couched in id terms may be perfectly relevant to the dynamics of the patient's difficulty, but at the moment it is presented may be tangential or obfuscating.

The cautious therapist is one who may not manifest many of the attitudes mentioned in the two previous types. He is apt to make infrequent interpretations and is in a better position to establish communication with a schizophrenic as long as his caution does not arise from his uncertainty and his inability to recognize the patient's or his own anxiety. Thus, the therapist who is by nature rather more characteristically a listener, who is often slow to accept ideas until he has carefully thought them through, and who rarely or infrequently talks at conferences, is often at an advantage when dealing with

a schizophrenic. Although the patient may at first seem more active in his symptoms with such a therapist—particularly if the patient has been given to much acting out—he may gradually achieve a kind of communication with the therapist which it would be difficult for him to achieve with a more intellectually competitive therapist. The patient gradually learns to make more open remarks about the cautious therapist, sensing somehow that it is safe to do so. The therapist, in turn, speaks of the patient in terms different from those used by the more intellectual or dynamic therapist. For instance, he does not seem as sure of ultimate therapeutic success, and he is apparently more perplexed about what is going on. In general, he is not as intrigued by the meaning of symbolic processes and is therefore better able to observe the interpersonal situation. He may be more accepting of the patient's prospective social adjustment and is not as likely to guide the patient along cultural lines, to be a success of some sort, and to conform to the doctor's idea of what a success is. One special problem of this group, however, is that caution and a relaxed manner may actually be masking anxiety and uncertainty. If this is so, the therapist may eventually run into difficulty with the patient and may have to demonstrate that the patient is inaccessible or that another therapist should take over the case. Although this type of therapist may show less defensiveness during supervisory sessions than some of the other groups, he may have a real need for support and encouragement in making decisions. Since forceful intervention is necessary at times in the treatment of schizophrenics, particularly in the case of paranoid ideas, the therapist's caution may represent an actual handicap to the progress of therapy. The therapist may overlook a golden moment for intervention, and the patient may interpret this caution as fear or as a lack of interest. The increased confidence and good feeling that may follow a properly conducted supervisory session may allow such a therapist to discover certain attitudes in himself that tend to shut the patient up.

An overly cautious therapist reported during a supervisory session in a manner that made it obvious he was discouraged with the progress of his patient. The therapist stated that the patient, who in the beginning had been quite accessible, had now become silent and unapproachable. The amount of despair he experienced made him unable to regard this as a temporary block in therapy; rather, it seemed to write a finis to his efforts. He approached the interview following the supervisory session with full awareness of his own dread of the hour, and the patient seemed, surprisingly enough, to be attempting to make the therapist more comfortable. For example, he met the therapist at the entrance to his office rather than in the day-room, which was their usual rendezvous. This small show on the patient's part seemed to contribute to a quality in the interview that contrasted sharply with the interviews of the previous two weeks. The boost that patient had given him was enough for the therapist to be able to remark spontaneously in the next supervisory session that he suspected that some of the patient's provocative ways had been greeted with a silence that actually reflected anger and disapproval on the part of the therapist.

There is occasionally encountered among a group of young psychotherapists working with schizophrenics one who will stand out among his colleagues by virtue of being a nonconformist. Such a person may be loosely spoken of as manifesting "overidentification" with his patients. He often manifests sizable difficulties in his own interpersonal dealings, and, although socially he may tend to be brusque and to avoid much that can be interpreted as friendly or tender, his patients may experience him as a warm person. The schizophrenic's low self-esteem may not be threatened by such a person, and the therapist in his conversation about the patient reveals a rather strong tendency to side with him against the hospital, ward administrator, or whatever authority seems most relevant. Such persons, because they may be especially gifted, present sizable difficulties for the supervisor. In his attempt to be of help, the supervisor may simply succeed in getting the therapist's back up. Such an encounter will usually be but one of a number of similar encounters with authority figures and a further link in the chain that successfully isolates this person and his pa-

tient from the rest of the therapeutic community.

A therapist of this type returned home one evening to find that one of his patients, who had privileges outside the hospital at the time, had done irreparable damage to his highly prized garden. After recovering from his initial dismay, he accepted it rather philosophically as a communication from the patient that the therapist was spending too much time in his garden instead of with the patient. The inability of the supervisor to be of aid in this situation was one part in a pattern that succeeded in causing the patient to leave the hospital, and the therapist himself left shortly afterward.

A therapist of this type may say to the patient, in effect, "I know because I've been there myself." He may, in fact, have been close to psychosis with or without awareness of it, and his adjustment may be primarily obsessional or schizoid. The danger of the development of a paranoid twosome between the patient and the therapist is very real in this kind of integration and they may feel that the rest of the world is responsible for their joint difficulties. The nonconforming therapist may be especially gifted in resolving the acute phase of the patient's psychosis, and his early results may be very encouraging. As treatment progresses and the patient reaches the therapist's level of adjustment, the pace begins to slacken. Perhaps it should be a more standard procedure in the treatment of schizophrenics for this kind of therapist to be used in the early stages of treatment, with a change in therapists as treatment progresses.

Although most people in our culture to some extent adopt a counterphobic way of life, this attitude can be exaggerated in a therapist to the point that he denies any fear of treating a schizophrenic. Such an attitude, if marked, might be labeled "the counterphobic attitude in therapy." The therapist who reacts in this way likes to work with schizophrenics partially because he is reassured by his ability to "stick out the hours." Since this attitude is a cover for intense anxiety, the schizophrenic is apt to react to it in one of two ways: His precarious self-esteem may be further damaged by seeing the therapist as a superior, unapproachable person, or he may feel that the therapist is bluffing or lying, in which case he is almost invariably reminded of someone in his past. The patient in such a situation may attempt to humiliate the therapist, or on occasion to attack him physically. The situation can often be resolved if the therapist faces his fears realistically and directly communicates his fear to the patient, for instance, by seeing him in a hot pack.

These categories of therapists are obviously unsatisfactory, arbitrary, and overlapping. They are presented only to emphasize that one of the primary tasks in the successful psychotherapy of a schizophrenic is the understanding of his interaction with the personality of the therapist. Knowledge of dynamics and techniques will increase the therapist's security and effectiveness only if used against the background of knowledge about his own interaction with the patient. In addition, theory can be an encumbering protection for the therapist instead of an aid to understanding the patient.

It will be noted that the phenomena described as being important aspects of the therapist's personality are largely manifestations of anxiety, either as it erupts into the treatment situation or as it is observable in terms of the psychiatrist's defenses against it. It would be fatuous to say that the absence of anxiety in the therapist would aid the treatment situation. It is more pertinent to search for fortunate ways of handling anxiety. As present-day observational techniques improve, so will our knowledge of the therapeutic implications of the therapist's personality and so will our ability to make the most of our imperfections.

One therapist's defenses may be found to be most efficacious and least encumbering in the early phases of treatment, while another's will be more suited to the long haul of working through. The use of multiple therapists to support each other, and hence reduce their individual anxieties and increase their individual awareness, seems to offer an avenue for research.‡ The presence of

‡ References 6 to 8.

more than one significant figure dilutes the untherapeutic aspects of each therapist and the reaction of the patient to any one of the therapists. The schizophrenic's uncompromising tendency to split good from bad seems to have a happier outcome when there is more than one person to divide. Still another possibility should be explored, namely, whether the therapist experiences less anxiety if he is supported in his decisions by another physician who serves as an administrator.§ This had proved efficacious as well with the psychotic not in the hospital. The therapist is freer to do therapy when the decisions regarding medical matters, privileges, and so forth, are in the hands of an administrator.[11]

It seems reasonable to speculate that increased awareness of the importance of the personality of the therapist in the psychotherapy of schizophrenics will lead to changes in our techniques with the end in view of reducing his anxiety in the treatment situation.

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