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Curative Factors in the Psychotherapy of Schizophrenic Patients

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Table of Contents

Curative Factors in the Psychotherapy of Schizophrenic Patients

The Revision of Psychoanalytic Approaches

A Conceptualization of Schizophrenic Disorders

The Family in Human Development

Deficiencies of Families of Schizophrenic Patients

Developmental and Regressive Schizophrenic Disorders

The Central Therapeutic Task

Establishing a Therapeutic Relationship

Gaining Trust

Avoiding an Omniscient Role

The Therapist as Participant Observer

Clarification of Schizophrenic Communication

Finding a Working Distance

Closure of the Therapeutic Relationship

Working with the Patient's Actual and Tangible Problems

Characteristic Times of Onset

Preparedness to Hear Primitive Material

Utilization of Information from and about the Family

Patience

Understanding the Patient’s Life

Anticipating Disruption of Therapy

Anticipating Parental Disruption of Therapy

Understanding Parents’ Problems

Treating the Thought Disorder

The Need for a Comprehensive Therapeutic Approach

Family Therapy

The Therapeutic Community

Neuroleptics

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Curative Factors in the Psychotherapy of Schizophrenic Patients

Theodore Lidz and Ruth W. Lidz

The editor of this volume has confronted us with the challenging task of presenting the curative factors in the psychotherapy of schizophrenia—a disorder that many psychiatrists consider incurable, and certainly untreatable by psychotherapy. We believe that schizophrenic disorders are primarily psychogenic (see Lidz and Lidz, 1949, 1952; Lidz, Fleck, and Cornelison, 1965), and have learned from our work with patients and our supervision of younger therapists that psychotherapy can foster critical changes in schizophrenic patients' understanding of themselves and ways of relating to others so that many can thereafter lead reasonably normal and sometimes highly successful lives. Cure? Well, we know a number of chronically schizophrenic patients who have recovered more completely than have many severely neurotic analysands. This woman who had been delusional, paranoidally fearful and antagonistic for several years while in excellent psychiatric hospitals is now a tenured professor in a leading university. This young woman who became psychotic shortly after starting college was transferred to the Yale Psychiatric Institute from another private hospital after her condition deteriorated. Now, after three or four years of

psychotherapy, she is far more capable of leading an independent and well-organized life than she was before she became psychotic. Enrolled in a leading conservatory, she is again on her way to becoming an outstanding musician. Those who have followed the transformation of withdrawn, disorganized, and delusional patients into well-functioning persons know that psychotherapy can accomplish what no other treatment of schizophrenic patients has even approached.

We have not started the chapter with these paragraphs simply as a profession of faith, but because in the tradition of William James we consider that when we cannot know in advance just how much is determined by circumstances beyond our control and how much by our effort and will, the belief in the possibility of succeeding is one of the factors that can produce success: the antecedent belief in the possibility can be important in bringing about the actuality (James, 1907). The therapist's confidence in the potential efficacy of his efforts is an essential ingredient in the treatment of schizophrenic patients, particularly as psychiatric tradition is weighted heavily against psychotherapy. Belief in the efficacy of psychotherapy is not the curative factor, but without it psychotherapeutic efforts have little chance of success.

The Revision of Psychoanalytic Approaches

The increase in our understanding of the nature and origins of schizophrenic conditions has altered our psychotherapy considerably and provided clear goals and guidelines toward achieving those goals. Psychotherapy no longer consists of efforts to bestow unconditional love to offset the hypothesized maternal rejection; or providing symbols of nurture in the manner of Sechehaye (1951), or making early and constant interpretations of the patient's supposed projective identifications as carried out by Rosenfeld (1965) and others of the Kleinian school; or making intuitive "direct" and "deep" interpretations in the style of John Rosen (1947); or permitting the patient to live through the psychosis with minimal interference as Laing has taught (see Boyers and Orill, 1971; Evans, 1976) in the belief that the patient will emerge more imaginative and complete than before the psychosis.

Indeed, although the psychotherapy of schizophrenic disorders has derived largely from psychoanalysis, it has had to free itself from certain constraints of psychoanalytic theory and technique. Of course, without an understanding of unconscious processes and primary-process cognition, pre-Oedipal development and the crucial importance of the Oedipal transition, as well as of repression, fixation, regression, and projection, the psychotherapy of schizophrenics could only have been carried out in a rather simple and primitive way. However, both the theory and practice of psychoanalysis were derived largely from the analysis of neurotic patients and are not fully suited

to the understanding of schizophrenic patients, or even to many of the seriously disturbed persons who currently are grouped together in the diffuse and ill-defined category of "borderline disorders."

Freud’s concept that schizophrenics’ narcissistic withdrawal of libido prevented the formation of transference relationships which made their analysis impossible kept most analysts from working with schizophrenic patients. It took many years and a willingness to disregard the opposition of psychoanalytic colleagues for Sullivan, Fromm-Reichmann, Lewis Hill, and others in the Baltimore-Washington area (aided by the influence of Adolf Meyer and John Whitehorn) to demonstrate that even though a schizophrenic patient could not develop a transference, a therapeutic relationship could be formed. The theory that schizophrenic disorders were due to fixations at the early oral phase of development led many analysts to try to compensate for the hypothesized early infantile rejection or deprivation. Although most analysts who have worked with schizophrenic patients modified classical techniques, most have found it difficult to free themselves of some techniques that are not simply of little value but are actually countertherapeutic. Psychoanalytic technique with its relative passivity, waiting, maintenance of anonymity, fostering of free association, emphasis on interpretation by the analyst, the search for the sources of distortions only within the patient, and the analyst’s isolation from the patients’ relatives can all impede, if not prevent, the development of a productive therapeutic experience, for reasons

we shall examine.

The new guidelines that permit the psychotherapy of schizophrenic patients to become increasingly successful derive from the development of theory based on work with schizophrenic rather than neurotic patients, and particularly from studies of the families in which schizophrenic patients grew up (Lidz and Lidz, 1949, 1952; Reichard and Tillman, 1950; Frazee, 1953; Bateson et al., 1956; Wynne et al., 1958; Alanen, 1960, 1966; Lidz, Fleck, and Cornelison, 1965). Here we can only indicate the modifications in theory that have so greatly influenced the understanding and therapy of schizophrenic patients.

A Conceptualization of Schizophrenic Disorders

It is necessary to grasp how this disorder which virtually eliminates ego functioning—the ability to direct one's life—need not be the result of neural dysfunction but can be a type of personality maldevelopment. We consider schizophrenic conditions to be types of withdrawal from living with others; from responsibility for making decisions concerning unsolvable problems; from the incestuous or murderous impulses toward a parent who blocks movement toward individuation and individuality; and particularly from experiencing the unbearable pain, disillusionment, emptiness, and hostility of being deserted or betrayed by those one needs and has sought to love.

Schizophrenia is not simply a withdrawal into a fantasy world; also it is an escape by breaking through the confines set by the language and meaning system of the culture without which one is scarcely human. When these essential constraints (upon which paradoxically the human potentialities depend) are disrupted, the screening functions of categories and concepts dissolve and the patient is flooded by inappropriate associations, deeply repressed intercategorical polymorphous perverse childhood fantasies, and regressions to childhood preoperational or preconceptual magical and egocentric thinking. It is an orientation that does not consider the origins of schizophrenic disorders to be unknown, but rather that such disorders are anticipated anomalies in the developmental process of humans who depend so greatly on those who raise them for their security, socialization, gender identity, superego formation and to guide their learning of language upon which persons depend so greatly to be able to think clearly, reason, direct their own lives, and collaborate with others.

The Family in Human Development

As psychoanalysts, our orientation to human development and its pathology has been greatly modified by our psychotherapeutic work with schizophrenic and borderline patients and their families. In contrast to the explicit and implicit assumptions of psychoanalytic theory and the so-called "medical model," the emergence of an individuated, reasonably integrated

adult at the end of adolescence depends on far more than proper physical and emotional nurture and freedom from physical and emotional traumata. Humans are unique among all living organisms in that most of their basic adaptive techniques are not inborn but must be acquired from those who raise them. Homo sapiens emerged essentially by the selecting out of mutations that progressively increased the capacity for tool bearing and language. Language enabled humans to convey what they learned to future generations so that knowledge became cumulative and cultures developed. Unless we realize that humans are born with a dual endowment—a genetic inheritance and a cultural heritage—we can never understand their functioning and malfunctioning correctly. We must also recognize that human beings' capacities to think, make decisions, and plan toward future goals depend on the proper acquisition of a language. People everywhere learn the basic techniques for survival and for living with others within a family or some planned substitute for it. For such reasons the family is an essential concomitant of the human biological makeup. In order to develop into a reasonably integrated adult, the child must receive considerable positive input from the family. We cannot in this chapter concerned with psychotherapy enter upon the family's requisite functions for rearing children, and must refer the reader to previous writings. The family's child-rearing functions can be categorized under the headings of (1) nurture, (2) the structuring of the offspring's personality, (3) basic socialization, (4)

enculturation, including the proper guidance of language development, and (5) providing models for identification for the child to internalize (Lidz, 1963).

Deficiencies of Families of Schizophrenic Patients

Careful studies of the families in which schizophrenic patients grew up (Lidz et al., 1965; Alanen, 1966) have shown that these families are incapable of carrying out adequately any of the requisite functions, which results in many serious deficiencies in the offsprings' personalities which leave them vulnerable to both disorganization and regression.

Moreover, the families that produce a schizophrenic offspring are found to have particular characteristics that interfere with the final stage of the separation-individuation process at the end of adolescence. Schizophrenia is essentially a disorder of mid- and late adolescence; when the onset occurs later in life, it is found the patient had never adequately surmounted the critical developmental tasks of adolescence. Adolescence is the critical period when individuals undergo a marked change in their relationships with their parents and should virtually complete the lengthy process of separation from them to achieve individuation as reasonably well-integrated, self-sufficient, and self-directed persons capable of relating intimately with someone outside the family. It is a time when parental directives become self-directives but

modified by the ways of other idealized figures. Persons who become schizophrenic have been unable to accomplish such developmental tasks, not simply as a result of maternal rejection or oversolicitude in early childhood, or because of some innate incapacity to develop stable object relationships, but because the family transactions throughout their formative years were seriously disturbed and distorting, and failed to provide them with the essentials for development and individuation by the end of adolescence or early adult life. The basic difficulties seem to derive from the egocentricity of one or both parents, who could not relate to the child as having feelings, perceptions, and wishes discrete from the parent's, but rather who needed the child to remain an adjunct who could complete and give meaning to the parent's life (Lidz, 1973a).

In one type of family (Lidz et al., 1957) that is particularly characteristic of families of male schizophrenics, one parent, usually the mother, cannot properly differentiate her own feelings, needs, and perceptions from those of her child; she expects the child to remain a part of her and provide a sense of completion to her life which is unsatisfactory largely because she has little regard for herself as a female. The mother's ways of relating to her children and rearing them are not countered by the father who is passive or ineffectual within the family. Children, especially sons, raised in such families may be unable to overcome the symbiotic tie to the mother, have problems with gender identity, and fear their incestuous impulses when they reach

adolescence. They lack an adequate male figure with whom to identify and follow into adulthood.

In another type of family that is more common among female than male schizophrenics, the parents have been caught in an irreconcilable conflict, compete for the loyalty of the child, undercut one another's worth, and provide opposing directives to the child. The child is caught in continuing binds (Weakland, 1960), as satisfying the directives of one parent provokes rejection by the other. In each of the above family types, as well as in admixtures of the two, parental gender roles are reversed or confused, generational boundaries are broken, Oedipal attachments are fostered rather than resolved, and the intrafamilial communication fragmented, amorphous, and in some respects irrational. Further, the atmosphere of the home is pervaded by a sense of futility, a hopelessness about ever gaining any real satisfaction from marriage or family life (Lidz et al., 1958; Wynne and Singer, 1963a, 1963b; Singer and Wynne, 1965a, 1965b).

Developmental and Regressive Schizophrenic Disorders

Some patients have grown up within families that were so seriously disturbed, so lacking in essentials, and communicated so vaguely or aberrantly that the patients have never been able properly to emerge from the family nexus as independent children or adolescents and may be

considered *developmental* schizophrenics akin to "process" schizophrenics. It seems likely that when the onset is in early or mid-adolescence, the mother has had particular difficulties in fostering the patient's individuation from her, and because the father fails to stand between the child and the mother, the Oedipal ties burgeon into incestuous ones. However, many schizophrenic patients function reasonably well within the family while dependent on parents for making decisions and are sheltered within the family, but become perplexed, lost, and unable to cope with independent living. When unable to surmount the developmental tasks of late adolescence, they not only regress to an anaclitic or symbiotic dependency but also return to preoperational, egocentric, magical forms of thinking in which the filtering functions of categorical cognition are lost (Lidz, 1973b). These patients my be termed *regressive* schizophrenics, akin to "reactive" schizophrenics. In addition to the serious problems that existed in their families throughout the patients' lives, the parents may be particularly "binding" (Stierlin, 1974) when their adolescent child needs to move beyond the family. Developmental and regressive schizophrenia are not separate entities but polar paradigms. Most schizophrenic patients fall somewhere on the continuum between these poles.

The Central Therapeutic Task

A therapist gains definitive guidelines for therapy when he recognizes

that schizophrenic patients' inabilities to overcome their symbiotic ties to a parent to become individuals with firm self-boundaries and capacities to direct their own lives derive primarily from parental difficulties in releasing them and from the deficiencies and distortions of the families in which they grew up. The central therapeutic task—perhaps in view of the title of this volume we should say, the essential curative aspect of therapy—lies in releasing these patients from the bondage of completing a parent's life, or of bridging a parental schism to enable the patients to invest their energies in their own development and to develop boundaries as distinct persons capable of making decisions and accepting responsibility for their decisions. The therapist consistently and persistently seeks to foster patients' latent desires for individuation; and through the therapeutic relationship counters their fears of rejection if they assert their own needs or express the hostile side of their ambivalent feelings. The therapist needs to provide support when these patients face their fears of independence and the unbearable emptiness they suffer if they become responsible for their own lives. The therapist confirms the patient's worth as an individual through considering the patient's feelings and perceptions as potentially useful guides to living. This usually means that the patients must come to realize that their parents—whom the patients believed knew the way and why of living—were themselves struggling to retain their emotional equilibrium and had rather aberrant ways of perceiving and relating. When schizophrenic patients

become capable of regarding their parents and the intrafamilial environment differently from the ways their parents needed and required of them, and begin to trust their own perceptions and feelings instead, they will have moved a long way toward emergence from their psychoses.

We have stated the crucial objectives that the psychotherapist strives to achieve and keep in mind through the many vicissitudes in his relationship to the patient; but how to pursue them with a patient who has withdrawn into his own world, who has no interest in therapy or a therapist, who pays more attention to voices the therapist cannot hear than to what the therapist says or does, whose words no longer adhere to conventional meanings, and whose understanding of his or her experiences is delusional? Even when some sort of relationship is established, therapeutic efforts are beset by difficulties in communication, sudden reversals in attitudes toward the therapist, inordinate expectations and demands that can dishearten the therapist sufficiently to drop psychotherapy in favor of neuroleptic drugs or to turn the patient over to a therapist more masochistically inclined than himself.

Establishing a Therapeutic Relationship

The first task is to establish a therapeutic relationship with the patient. As it became evident that a therapeutic relationship could be established with schizophrenic patients, some analysts insisted that the schizophrenic did not

form a transference relationship but rather, a dependent, anaclitic one. We believe that this argument is essentially correct and leads to some of the basic problems encountered in working with schizophrenic patients. The therapist's recognition that the patient, despite fear of engulfment and desire for an independent existence, also seeks to become dependent again on an omniscient and omnipotent person who can solve his problems and provide nurture and protection in an alien world, provides guidelines both for establishing a relationship, as well as for maintaining and for developing it into a more mature relationship. The understanding clarifies why a therapist's overcommitment—including efforts to provide all-encompassing love and to make interpretations for the patient rather than finding them together—can be detrimental. A basic task confronting the therapist is that of transforming the patient's anaclitic relationship into a proper object relationship, or at least into a relationship in which the patient can examine his life together with the therapist and begin to assume responsibility for himself.

Gaining Trust

Thanks to the moderate use of neuroleptic agents—the dosage must be kept moderate for heavy dosages interfere with cognition—as well as improvements in milieu therapy, the therapist today is only rarely faced with a patient who is mute, unresponsive, or wildly excited for months. The

essential problem is to gain the trust of a patient who has—because of disillusionment with significant persons, despair over the present, and hopelessness about the future—withdrawn into a private world and regressed to childhood ways in which preoperational magical thinking seems to bestow power to control events. When patients can tentatively trust the therapist not to desert when needed or use them for the therapist's prestige or self-esteem, patients will once again take the chance of suffering the pain of disillusionment because the loneliness of their self-imposed isolation is difficult to endure.

Trust is established through the therapist's interest, thoughtfulness, and efforts to understand the patient's dilemma and grasp what the patient seeks to convey even as he or she seeks to hide thoughts and feelings. Human relationships rest on communication, verbal and nonverbal, and the therapist often faces the difficult task of finding a way of establishing communication with a person who is using an idiosyncratic language. This is not the time for the therapist to remain aloof and, following analytic technique, act as a passive screen against which the patient can react. The patient is lost, and hope and trust must be rekindled. The anxiety provoked by a therapist's relative unresponsiveness is more likely to paralyze than energize. The schizophrenic patient is ever alert to pretense, which may include the therapist's hiding behind a prescribed role. These patients will usually respond only to a real person who is interested in them as individuals—as

individuals who are confronted by problems that seem insurmountable, but which the therapist and patient are trying to understand together. The therapist must differentiate between being kindly and being condescending; remembering that even when a psychotic patient acts like a child or infant, he is not a child, and much less an idiot. There is also need to differentiate between being tolerant and understanding and being indecisive and weak. The patient usually needs the security of a firm and assured therapist. Although the patient has withdrawn for self-protection, the therapist must assume that, like all persons, he or she wishes to be understood, respected, and able to share again with another.

Avoiding an Omniscient Role

The therapist's recognition of the patient's symbiotic or anaclitic ways of relating can help establish a relationship that will not collapse because the patient becomes disillusioned. Even though the patient may have attained some degree of independence, when regressed, he or she will seek an omniscient figure who will provide answers, make decisions, and omnipotently provide security in a dangerous world. Therapists who take charge and direct the patient's life, as well as those who make striking intuitive interpretations of the patient's unconscious processes, may achieve brilliant initial results, but they base the relationship on means they cannot sustain, and sooner or later the patient will once again become disillusioned

and withdraw. These patients, like the small preoperational child, are incapable of ambivalence (rather than suffering from ambivalence as Eugen Bleuler [1930] believed). They tend toward "splitting," considering a satisfying person "good" and a depriving or punishing person "bad"; and when the omniscient therapist does not understand or fails to protect, he is "bad." Although the schizophrenic patient initially may relate well to a therapist who presumes to know the answers, who directs, and who provides the greatly needed affection, it plays into the patient’s belief that someone else knows the way and will care for him magically. Indeed, the need is usually so great that the patient places the therapist in this role even when efforts are made to avoid it. Ultimately, frustration turns the benevolent therapist into a malevolent figure, for the omnipotent figure fails to protect. The therapist must try from the very start to avoid being considered omnipotent, on the one hand, and being like the parents in needing the patient, on the other. Overprotecting, or giving the impression of intuitively or mystically understanding the patient, fosters one need, while masochistically accepting the patient’s unbridled demands or condemnations fosters the other. The therapist must be ready to go a long way and even inconvenience himself to help the patient, but must avoid controlling as well as being controlled by passive measures. The strength that a therapist must convey to the patient may well derive from having sufficient integrity not to need to be infallible. The therapist does not insist or even imply that he is

"right" and the patient is "wrong," for the therapist’s willingness to consider that he may be wrong, annoyed, or may have inadvertently hurt the patient helps the patient become aware that more than one meaning can be placed upon an incident and prepares the way for the patient to overcome his cognitive egocentricity.

The Therapist as Participant Observer

Examining life situations and the therapeutic relationship together *with* the patient, as Harry Stack Sullivan taught, rather than making interpretations *to* the patient is important for several reasons beside avoiding being placed in an omniscient role. The patient had in all likelihood been told how to think and feel by his parents, and the patient must be encouraged to think for himself. The patient is likely to agree with an interpretation but pay little heed to it, or he may disagree in an effort to preserve his autonomy. Examining the therapeutic relationship as well as the patient’s past experiences together indicates the therapist’s consideration of and respect for the patient’s opinions and abilities, which may be a very novel experience for the patient. This approach is especially helpful with paranoid patients, who can participate in analyzing situations but cannot let others tell them what something means or trust another to direct their lives. Above all, the therapist seeks to work in an alliance with the patient, and to avoid an adversary role despite provocation.

Clarification of Schizophrenic Communication

The patient’s communications are likely to be vague and confused by magical thinking and intrusive associations. The therapist is under no obligation to understand, but he is obligated to listen and try to hear what the patient seeks to convey or to conceal. Rather than interpret, the therapist tries to clarify what the patient says in a way that the patient can follow. The psychiatrist may comment, "From what you have been saying, do I understand that you mean—" or "Yesterday you said so and so but today you say—Are you uncertain about how you feel?" As progress is made, firmer means of clarification may be warranted: "You have said this—and this—and this. It seems to me that this all means—"

In general, the therapist does not shy away from topics mentioned or even hinted at by the patient because they seem too touchy at a particular stage of therapy. Schizophrenic patients are likely to assume that the therapist hears everything, and if the therapist avoids a topic, it must be completely unacceptable. The topic or concern is at least acknowledged and the patient told that they can consider the matter when the patient feels ready to do so. Knowing how to make comments that will be meaningful to the patient who is ready to discuss a certain topic but can be passed over by the patient who is not ready is a therapeutic skill that one must cultivate in work with seriously disturbed patients. Thus, when a patient talks of the

craziness and confusion of the hospital unit without showing any indication of being upset by it, his therapist comments, "You seem to feel quite at home here." The patient accepts the phrasing and goes on to discuss the disorganization of his home—a topic he had sedulously avoided a week earlier.

Free association has little if any place in the treatment of schizophrenic patients, as least not until the patient has clearly emerged from the psychosis and is continuing therapy better to understand his life. The patient who is likely to be flooded by extraneous egocentric associations and primary-process material, and to regress to preoperational cognition, needs first of all to regain the filtering function of categories and the use of shared meanings and syntax. The therapist seeks to strengthen the patient’s ego functions rather than to encourage nebulous fantasy or rumination. For related reasons, anxiety is not fostered to gain therapeutic movement, for stimulating the sympathetic nervous system lowers the neurophysiologic stimulus barriers which can increase cognitive disorganization. When the patient becomes anxious or hostile when discussing or thinking about something, it is taken as a sign that he must decide what to do to alleviate such feelings. Feelings of anxiety and hostility are welcomed as directives that indicate a need to examine a circumstance so that the patient can find ways of changing it, or his attitude toward it.

Further, in contrast to the analysis of neurotic patients, the therapist does not analyze patients' defense mechanisms so much as the distortions imposed by the parents' defenses of their own tenuous egos. Efforts are made to imbue in patients trust in their own ideas and feelings, while questioning those that are essentially the parents' feelings and percepts that patients offer as their own. Patients are usually sensitive and responsive to the therapist's ability to differentiate the two. "I don't understand why I had this breakdown," the patient said. "Fve a good family, loving parents and a fine, healthy brother and sister." "I wonder who told you that," muses the therapist. The therapist seeks to foster patients' self-esteem and trust in their own ideas and feelings, which they have been taught to eschew in favor of what their parents projected onto them.

Finding a Working Distance

It is essential for the therapist to find and maintain a suitable distance for working with the patient, to be friendly and supportive and at the same time counter the patient's tendency to conceive of him as an omniscient and all-powerful protector. It is almost impossible, however, to find a distance that is satisfactory to the patient that will not also lead to some difficulties. Many patients who have a desperate need for closeness have at the same time an extreme fear of it, and become panicky over fears of fusion, engulfment, and loss of the self. At times any deep interest may be considered a promise of

all-protective love, and earlier incestuous wishes can turn into an expectation of a sexual relationship or marriage with the therapist. On the other hand, patients may believe that their own basic malevolence, or the negative side of their ambivalence can kill the therapist they need so desperately, and therefore fear closeness. The "How are you?" with which a patient opened each session was not a casual greeting; it was accompanied by a haunted, scrutinizing look to see if the psychiatrist was surviving the danger of the patient's sucking neediness.

The difficulties in finding a proper distance involve countertransference as well as transference problems. Therapists require firm self-boundaries to avoid confusing their own needs with those of the patient and to resist being overwhelmed by the patient's hopelessness, despair, and demands. Therapists cannot, like the patient's parents, need fulfillment through the patient, or convey that their well-being or future depends on their patient's recovery. There is a critical difference between the therapist's being warm, giving, and highly interested, and letting the patient become significant on a personal rather than professional level—a difference that can be difficult to maintain when the patient demands love and throws out the challenge, "You don't love me; I don't mean anything in your life, I'm just a patient to you." Therapists properly have other sources of love, persons other than patients who provide meaning and solidity to their lives; and in the long run the patient gains security from knowing it. In any long-term therapy with a

patient who gives evidence of being reborn because of the therapist’s efforts, the patient is almost certain to become very important to the therapist. The relationship is far from casual for the therapist, but the "love" should be "parental" in the sense of pleasure and even pride in the patient’s growth and increasing independence, and should convey that the therapist will be pleased when the patient can emerge from the relationship with, and need for, the therapist, and thus counter the earlier "binding" and "engulfing" love of the patient’s parents.

Closure of the Therapeutic Relationship

The therapist necessarily becomes extremely important to the patient. In general, the desire for an intense anaclitic or symbiotic relationship modifies over the course of therapy, and the therapist becomes a model for identification, a stable model with clear boundaries and clear thinking, in contrast to the parental models. This is one reason why the patient needs the therapist to be a real person. Eventually, the patient internalizes the therapist as something of a superego figure with whom to carry on imaginary conversations to reach decisions or to gain support, even long after therapy has ended (Rubenstein, 1972). In some respects the transference is not worked through completely, as is attempted with neurotic patients. Patients may need to retain the belief that, if serious difficulties arise, the therapist will be there to help extricate them. Some former patients write or telephone

from time to time simply to be certain that the therapist is still alive and potentially available.

Working with the Patient’s Actual and Tangible Problems

One of the most important contributions that family studies have made to the psychotherapy of schizophrenic disorders is simply that therapists can be certain that schizophrenic patients face very real problems in their current life situation, problems that either concern the long-standing difficulties in the family transactions or rather clearly derive from them. It is on these very real and tangible problems that the therapist seeks to focus as soon as feasible. It is here, rather than with the interpretation of delusional material, or the patient’s projective identifications, or other intrapsychic processes, that the therapist starts as soon as feasible. An awareness of what sorts of difficulties confronted patients when they became psychotic helps the therapist hear what they may be wishing to convey even as they seek to conceal, and provides suggestions of how best to respond in order to foster a therapeutic relationship. The keys to such awareness derive from several sources: material from studies of the transactions in the families of schizophrenic patients; knowledge of the preoccupations, fears, and conflicts common to many schizophrenic persons; awareness of the characteristic times of onset; and how these can all interrelate.

Characteristic Times of Onset

There are several critical junctures in development at which schizophrenic disorders are likely to appear. When the onset occurs shortly after puberty, the patient is apt to be so deeply enmeshed in a symbiotic relationship with the mother that relationships outside the family are precluded. The first remark of one such patient to her therapist was, "I can’t walk without my mother." Further, the symbiotic bond leads the new sexual impulsions into incestuous channels, a direction fostered by one parent’s incestuous proclivities and the inability of the other parent to stand between the patient and the seductive parent. The frequency of onset shortly after the patient leaves home for college or the armed forces is related to the parents’ inability to consider that their child can manage on his own and make decisions by himself, much as in school phobia; to the lack of adequate integration to replace the structuring provided by the family; and the lack of capacities to relate to and communicate with strangers. Another time of onset —so common that it is difficult to realize that it had not been recognized until rather recently—is when the parents divorce or are seriously considering divorce. The patient then feels hopeless about ever becoming free of the obligation to complete the life of a parent, panic-stricken because the divorce fans the incestuous fantasies fostered by the nature of the parent-child interaction, and, in some cases, feels torn between the parents but also hostile about being deserted. The precipitation of the psychosis by the later loss or

threatened loss of a needed person usually reflects an earlier, poorly integrated desertion by a parent.

The therapist can be certain that some such precipitant has occurred and that serious intrafamilial situations exist that are central to the patient’s dilemma. Moreover, the therapist can feel confident that the problems are neither beyond the reach of a psychotherapeutic approach, nor that they can only become accessible after prolonged analysis. Such confidence is essential because the therapist must arouse some hope in a patient who has given up coping with life and the important persons in his life. From family studies and our own extensive experience, we feel warranted in saying that the therapist can be certain that serious intrafamilial problems always exist. Further, the nature of the difficulties may become apparent to the heedful at the initial interview with the parents. It is on such tangible problems that the therapist seeks to focus as soon as feasible—which, of course, may be many months. The therapeutic effort is directed toward bringing the patient to consider the life situations from which he or she has been fleeing and not to foster flight from them by working with delusions, fantasies, and "free" or random associations. As intriguing as the patient’s bizarre communications, delusional contents, or polymorphous perverse fantasies may be, the therapist is apt to be tapping a bottomless well that enriches the therapist but does not much benefit the patient unless the material is used to clarify current real dilemmas. As Freud taught, delusions are restitutive measures

and are needed by the patient until the serious life impasses have been examined and understood, if not overcome; delusions are rarely resolved by uncovering their unconscious meanings. However, patients cannot be expected to face the life situations that precipitated a psychosis until they can again trust someone—usually the therapist—not to desert them in their need and can believe that the therapist will not reject them after learning the nature of their impulses and fantasies, but will be able to understand, will be able to survive their malignant feelings, and support them in their despair. The remark a patient made when her therapist sought to have her face the impact of the turmoil that preceded her parents' divorce is critical. The patient said, "You must be even crazier than I am if you think I'm going to let myself experience that despair again."

Preparedness to Hear Primitive Material

On the basis of experience with other patients as well as the collective experience of other psychotherapists, the therapist is prepared to hear material which schizophrenic patients initially may allude to in veiled ways to find out if the therapist can accept the dark, forbidden feelings that the patient has been unable to accept but which keep intruding and disturbing him or her. As therapy progresses material is likely to emerge that is far more primitive and bizarre than that produced by neurotic patients. Fantasies or delusions of sex change are frequently present in schizophrenic patients;

incestuous ideas seem to verge on emergence into action rather than have the quality of fantasy, for actual or near incestuous relationships are common in these families; murderous hostility toward a parent makes the patient seek to avoid the parents; polymorphous perverse fantasies, including cannibalistic notions or desires to drain a supportive figure by fellatio, emerge and may need to be heard lest the patient believe he is beyond help if not beyond consideration. Such material involving the therapist, if unanticipated, can lead the therapist to take distance from the patient. On the other hand, if it can be used as a guide in therapy rather than as an indication of abnormality, it can provide the patient with new motivation. Thus, a young woman's fantasy of being locked in a tight embrace with her therapist with each biting into the other's jugular vein and sucking blood from it led to a clearer understanding of the intertwining of her aggressive rage with her need for fusion, of how the fantasy arose before the therapist's vacation, and thence back into a new understanding of her feelings toward her symbiotic mother who fed on the patient while feeding her. A much more focused therapeutic relationship could then follow.

Utilization of Information from and about the Family

It is important that the therapist does not limit the content of talks with the patient to what he learns from the patient, or act as if that is all he knows, for in the treatment of virtually all schizophrenic patients information is also

obtained from relatives. Patients do not know the customs of psychoanalysis and properly assume that the therapist knows a good deal about them, and that the therapist's failure to talk about such matters is part of the mysterious conspiracy against them. The therapist needs information from the family and about the family, including impressions of the parents and how they relate to one another and their children. Some therapists prefer to gain an impression of the parents themselves, but others feel more comfortable having a social worker see the family. Of course, the patient must be informed that the family is providing information, but that the therapist is interested in the patient's version of events which, at least in many ways, has greater pertinence. Openness and directness are a therapist's major protection against being included in a patient's delusional system. If the patient is also in conjoint family therapy, as is often the case, what happens in family sessions should be considered grist for the mill in individual therapy. There is no reason, for example, why the therapist should not say to a patient who talks primarily about her delusions that her parents believe her troubles started after they forbade her to visit her boyfriend's home.

Patience

In the course of trying to establish a relationship with patients who are unwilling or unable to discuss their life situations, the therapist may usefully talk of a relatively neutral topic of known interest to the patient, and

preferably a topic that permits a patient to utilize an asset. Patients who block or become incoherent when they try to talk about their problems may become interested and chat meaningfully about a relatively impersonal topic. Their talk or behavior during a bridge game or at a football game may be entirely different from that during a therapeutic session. A therapist spent several months discussing Renaissance painting with a withdrawn and flagrantly delusional graduate student of art history—discussions that became increasingly animated and focused and which gradually turned into the patient's talking about the frustrations caused by her mother's efforts to push her into another field and then about how her mother had always intruded into her life.

Understanding the Patient's Life

In general, the therapist seeks to understand the patient's life; what blocked the patient's individuation and integration; what interfered with his capacities to overcome the problems of adolescence or to cope with one or more critical problems. The therapist's curiosity about filling the gaps that interfere with understanding makes the therapy a very active—that is, a mentally active—affair. The therapist not only listens and lets his own unconscious meet the material, as Freud taught, but also formulates to himself various alternative meanings to be verified, modified, or discarded in the future. The therapist puzzles over how a patient's remark fits in with

earlier material and conjectures; what comment or query can lead the patient to amplify, make connections, or clarify; what comment might counter the patient's egocentric understanding of an event or help foster ambivalence (as opposed to splitting); what comment might increase the patient's self-esteem, and so forth. Once the patient also becomes curious and puzzled, both patient and therapist are likely to do a good deal of work between sessions, and then silent or sterile therapeutic sessions become rare as both await an opportunity to clarify a bit more of what has been perplexing. When the therapist finally understands, the patient also will have gained understanding along with the therapist, and in the process will have learned much about thinking things through independently. The patient who has avoided thinking for fear of unbearable anxiety, hostility, disillusionment, or depression learns that such emotions can be used as signals that something is deeply troubling; that their source must be sought and an effort made to change the troubling situation or relationship. By helping patients sort out problems and possible ways of coping with them, the therapist helps them learn to make decisions—a critical aspect of ego functioning—but the decisions are to be made *by* the patient, not *for* the patient, except in emergencies.

Anticipating Disruption of Therapy

The therapist who appreciates the patient's anaclitic or symbiotic needs can anticipate various setbacks that might disrupt therapy. Commonly, just as

the patient seems to be forming an attachment to the therapist and the therapist dares to feel hopeful, the patient flees—sometimes from treatment, sometimes into a more regressed condition. Therapists can become profoundly discouraged and give up in actuality, or through losing their commitment to such patients, or by deciding to rely on pharmacotherapy. If, however, the therapist expects patients to flee because of fears that his or her growing attachment will again leave the patient vulnerable to disillusionment and despair, and the therapist refuses to be discouraged or pushed away, a major hurdle will have been passed and a firmer relationship will almost always follow.

Conversely, after a firm therapeutic relationship has been established, when the time comes for the patient to take a step toward increased independence—for example, when a hospitalized patient is permitted greater freedom or anticipates discharge—a resurgence of anxious emptiness occurs and the anaclitic depression that had been covered by the psychotic symptoms becomes apparent. The regressive flare-up of symptoms, and perhaps the efforts to find protective closeness or fusion by sexual acting out, can set back the therapeutic process unless anticipated and focused on in psychotherapy, with the therapist temporarily providing increased support. The appreciation of the anaclitic core of these patients' problems also permits us to understand the admixtures of schizophrenic reactions with amphetamine and LSD psychoses, anorexia, and nymphomania that have

changed the phenomenology of adolescent schizophrenic disorders so greatly in recent years.

It is at such times of movement toward increased independence that the therapist must be prepared to provide the patient with greater support. Support does not mean showing affection, or directing the patient's life, or making decisions for the patient. Rather, the therapist may let patients know in advance that they may become anxious or feel deserted, while reassuring them that the therapist believes they can take the step and that the therapist will be available to talk about what is happening. The therapist supports by firmness in expecting the patient to confront the difficulty, look at the anxiety or depression as a sign that something is amiss, and together with the therapist explore possible ways of dealing with it. The therapist further supports by seeing to it that the patient does not undertake more than he or she can reasonably expect to accomplish. The psychiatrist is also aware that it is at such times when the renewed insecurity may lead patients to recall matters that had been troubling them at the time they became psychotic, that critical problems can be worked through.

Anticipating Parental Disruption of Therapy

An understanding of the family situations of schizophrenic patients can help overcome a common major impediment to successful treatment: the

parent's premature and often abrupt removal of the patient from the hospital or from psychotherapy. Here the parents rather than the patient need help, and a therapist who feels that his contact with parents must be minimal requires a collaborator to cope with the parents' concerns. The symbiotic mother is very likely to believe that the patient cannot survive without her care and may suffer from such intolerable anxiety that she will take the patient home unless someone understands her predicament and helps alleviate her anxiety. A second cause of parental disruption of therapy has to do with a parent's fear that the patient's attachment to the therapist will disrupt the child's dependent relationship with the parent. A third occurs when the patient begins to show overt hostility to one or both parents, which they rather naturally regard as an indication of a worsening condition rather than as a move toward improvement, particularly if the therapist has avoided the parents or been hostile to them. Then, too, the parents may need to have a sick child at home to serve as a scapegoat—the apparent source of the family's unhappiness who masks the parents' incompatibility—or to provide some meaning to the parents' life.

Understanding Parents' Problems

The therapist's recognition that the parents' egocentricities, narcissism, attitudes, and ways of relating to the patient are important determinants of the patient's schizophrenic disorder sometimes leads him to regard the

parents as villains who have ruined the patient's life. The patient's illness is far more tragic to the parents than to the therapist; and the therapist must realize that their noxious influences were not malevolent, but the outcome of their own personal tragedies and emotional instabilities. They are no more to blame for their inadequacies than the patient is to blame for being schizophrenic. One or both parents requires support in order to be able to release his or her retarding hold on the patient. Neglect or hostile exclusion of the parents often leads to aggravation of the patient's condition even though the psychiatrist may believe such action protects the patient from their malignant influence.

Treating the Thought Disorder

The thought disorder is the critical attribute of schizophrenic conditions and requires specific psychotherapeutic attention. The thought disorder has usually been considered to result from primary-process intrusions, a concomitant of regression, and that with resolution of the patient's emotional problems, the primary-process thinking would subside. The thought disorder is a far more complex process, however, and involves regression to childhood precategorical forms of magical thinking, the paranoid mistrust taught in the home, the parents' failure to inculcate a solid grounding in the culture's system of meanings and logic, paralogical efforts to elude double-binding situations, intrusions of intercategorical polymorphous perverse material,

egocentric misunderstandings, an inability to feel ambivalently, projection of unacceptable impulses, and extrojection of poorly integrated parental introjects.

Therapists seek to be consistent and clear in what they say and attempt to clarify patients' vagueness. They help counter patients' overinclusiveness and enhance their focal attention by establishing definite boundaries between patient and therapist and foster such boundary formation between the patient and others. The patient's egocentric interpretations are countered by suggesting other ways of understanding events, and the capacity for ambivalence is fostered by working with the patient's shifts from love to hatred, and from acceptance to rejection to enable the patient to grasp that feelings about others are commonly ambivalent. We have focused specifically on finding ways of freeing patients from distorting their perceptions and meanings to fit their parents' aberrant ways of experiencing. As we have already emphasized, it is a difficult but vital aspect of therapy, and once accomplished, the patient is out of the mire and on more solid ground.

The Need for a Comprehensive Therapeutic Approach

This chapter has been concerned with the curative aspects of psychotherapy, and we have focused on individual psychotherapy. However, the treatment of most schizophrenic patients does not rest on psychotherapy

alone but is much more comprehensive (Lidz, 1973a). The chance that these persons can change profoundly to become integrated individuals capable of leading satisfactory lives has been greatly improved by the development of neuroleptic drugs, modern milieu therapy, and family therapy. Tranquilizers and milieu therapy have not made psychotherapy unnecessary but have made it more feasible and often more successful. To treat schizophrenic patients without considerable attention to the family in actuality, particularly in youthful patients, and to the internalized parental figures in all patients, is to neglect the essence of the problem.

Family Therapy

One very substantial advance has been the advent of family therapy, which may take many forms. Those who have conducted conjoint family therapy with the families of schizophrenic patients soon become aware of how closely intertwined are the distorted personalities and relationships in these families, and that often little movement can be expected in the patient's therapy unless there are shifts in the family's equilibrium or disequilibrium. With older patients, conjoint family therapy may not be necessary or possible, but individual therapy should focus on how the disturbed family transactions have affected the patient. Unless the therapist is alert to the fact that serious family problems exist, as they always do with such patients, they may never be brought into therapy because patients may not recognize the

abnormalities of the transactions in the families in which they grew up, or because they need to preserve a positive image of their parents.

The Therapeutic Community

Understanding patients against their families' background leads to an appreciation of the importance of the modern psychotherapeutic community in providing the necessary facilities. The common current practice of brief hospitalization and discharge of the patient on heavy tranquilization derives either from the belief that schizophrenia is basically incurable or from an awareness that widespread patient neglect in institutions fosters permanent regression. The proper traditional role of the mental hospital has been to provide a "retreat" from the life stresses that contributed to the psychosis. We now realize that the youthful patient also needs to be removed from the distorted and distorting family setting. Patients who have been unable to find an ego identity or to function as reasonably autonomous persons are granted a moratorium during which they are relatively free from parental intrusions and the need to make critical decisions, and during which they can marshal their inner resources and utilize therapeutic guidance. Hospitalization provides opportunities for patients to learn to relate more readily to others; to see other points of view and thereby modify their own egocentricity; to gain social skills that have not been learned in the family; to be in group therapy where they may see problems similar to their own in others before

they can see them in themselves and from the group processes become more capable of making decisions; and through family therapy gain a new orientation toward their parents as well as having the opportunity for the parents to modify their attitudes and the family transactions.

Young patients need to continue their schooling in a special school that takes into account their limited attention span and the intrusion of hallucinations, egocentric thinking, and their conceptual difficulties. When patients are hospitalized, therapists are no longer working alone. Others share the problem of delimiting the patient while at the same time improving the patient's socialization. The intensity of the anaclitic dependency is modified by the presence of other significant therapeutic figures, and the opportunity to relate to persons of the opposite sex from the psychotherapist can be very helpful.

Neuroleptics

The use of tranquilizing drugs can be a major factor in recovery when properly used, but it can also be a major impediment when overdone. The acutely psychotic patient whose anxiety and agitation are quieted by drugs may not need to find delusional answers to his perplexity; the disorganized patient is less overwhelmed by extraneous stimulation and distraught ideas. But it is virtually useless to try to conduct meaningful psychotherapy with a

patient who is receiving heavy doses of tranquilizers, and using drugs to enable seriously disturbed and delusional patients to leave the hospital interferes with their chances of developing, socializing, and overcoming the psychotic state.

The studies of patients against the family backgrounds in which they grew up have increased appreciation of the need for a comprehensive program of treatment, particularly for socializing experiences and for modifying parental attitudes as well as the patient's attitudes toward the parents. However, we believe that psychotherapy, and usually individual rather than group or family psychotherapy, forms the core of the treatment. The therapeutic relationship enables patients to emerge from disillusionment and despair to dare to trust and relate again—then to rework their intrapsychic relationships to the significant persons in their lives in order to separate from them and gain the ego strength to direct their own lives.

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