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Individual Psychotherapy of Schizophrenia

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There are marked disagreements as to the treatment of choice in schizophrenia. Many psychiatrists prefer physical therapies, especially drug therapy; in recalcitrant cases, convulsive shock treatment or insulin therapy; and, in some especially difficult cases some use of psychosurgery.

My own marked preference in the average case is individual psychotherapy, although with numerous patients I use a mixed psychotherapy and drug therapy. My "bias" is based on the belief that physical therapies, as far as we know or can infer, produce only a symptomatic improvement, whereas psychotherapy tends to (1) remove the basic conflicts which are important and necessary causative elements of the disorder; (2) correct the psychopathologic patterns; (3) change the self-image of the patient and therefore make him less vulnerable; and (4) permit the regenerative psychological powers of the organism to regain the lost ground.

These assertions should not be interpreted as a condemnation of physical therapies. On the contrary, I have found physical therapies, with the exception of psychosurgery, useful at times in a variety of situations:

1. When psychotherapy for psychotic patients is not available (and, unfortunately, it is not available to by far the majority of patients), physical therapies should be administered.

2. Psychotherapy is not effective in every case. Although in the last two decades we have made great progress in this field, our technique is still not completely satisfactory. We often encounter patients (fortunately, in decreasing number) who do not improve. In rare cases, every interpersonal relation, even that with the experienced therapist, increases the anxiety of the patient to such a point as to enhance his psychological disintegration. Perhaps, with the refinement of technique, such cases will eventually disappear; but, for the time being, if more than a few therapists have been unsuccessful and the condition is worsening (especially, in cases of rapid disintegration or those in which no contact at all is made), an attempt should be made to arrest the process, at least in a symptomatic way.

3. Finally, drug and even shock therapies must be used in cases which are urgent because of a concurrent physical illness. Here, quick results must be obtained before they could be achieved with the long psychotherapeutic procedure.

Even when shock or drug therapy is used with apparently successful results, psychotherapy is important in order to prevent relapses.

An increasing number of patients today are being treated with a combination of drug therapy and psychotherapy. The drug therapy decreases

the anxiety and makes them more accessible to (or less fearful of) the interpersonal contact. In my experience, this combination does not shorten the treatment but does have the advantage of making hospitalization unnecessary for many patients. In many cases, a full-fledged schizophrenic is transformed into an ambulatory schizophrenic. This transformation is not to be disregarded, as many patients are kept in the community in this way and are able to work while undergoing effective treatment. Drug therapy establishes a certain distance between the patient and his distressing symptoms, which may be welcome for therapeutic reasons as well. On the other hand, if the patient who receives drug therapy experiences less anxiety, he becomes somewhat less sensitive to psychotherapy, too. Thus, each case has to be evaluated individually. We have to decide in each instance whether we gain or lose more with adjuvant drug therapy. In a considerable number of cases the gain is greater than the loss.

No matter which treatment for schizophrenia a psychiatrist prefers, he cannot ignore psychotherapy, nor can he escape practicing psychotherapy with schizophrenics even if he is determined to do so. Even a psychiatrist whose practice consists predominantly in administering phenothiazines cannot help inquiring about the dynamics of the patient's anguish and conflict, cannot help observing and interpreting what happens between the patient and himself. He may not apply all the insights that people who have specialized in the psychotherapy of schizophrenia have revealed; he may not

follow all their recommendations, but some of them have been assimilated by him, even if in diluted forms. Moreover, even those who have enlarged the field of psychotherapy of schizophrenia to include family therapy, group therapy, and community psychiatry, have built upon the foundations laid by individual psychotherapy.

A historical review of the development of this type of treatment will reveal that each method adopted was the clinical expression or the therapeutic realization of one or a few underlying principles held by its originator. Often, the principle was deduced from the clinical experiences of the therapist; in several instances it was a preconceived theoretical view which oriented the therapist in certain directions.

A Historical Survey

Freud and the Freudian School

Any review of the psychotherapy of schizophrenia must start with Freud. And yet, paradoxically, Freud, to whom we owe so much for the understanding of many aspects of this disorder, discouraged psychotherapy with schizophrenics. To be exact, as early as 1905, he did not consider the obstacles to remain insurmountable in the future and did not exclude the possibility that some techniques would be devised which would permit the

psychoanalytic treatment of the psychoses. Later, however, Freud assumed a more pessimistic attitude. He felt that the psychosis could be compared to a dream and understood as a dream, but not cured.

An underlying principle was at the basis of this pessimism. Freud believed that in schizophrenia there is a withdrawal of libido from the objects into the self; therefore, no transference can take place, and without transference no treatment is possible.

One of Freud's first and famous pupils, Federn, made repeated and successful attempts in the treatment of schizophrenic patients, in spite of the prevailing discouraging theories. One of Federn's underlying principles was based on the concept of ego-feeling, that is, an autonomous reservoir of libido in the ego. He felt that the ego of the schizophrenic is poorer, not richer, in libido as Freud's theories implied. He also felt that transference with the schizophrenic was possible. As a matter of fact, he succeeded in establishing it.

Another tenet of Federn (of the ego boundaries), however, limited his therapeutic aims. Federn believed that in the schizophrenic "the boundaries" separating the areas of the psyche (the id from the ego and the ego from the external world) are defective, so that material from the id may invade the ego and even be projected to the external world. The most important goal of

therapy should be that of establishing normal boundaries. Reversing a famous sentence of Freud, Federn said that, as a result of therapy in the schizophrenic, “There, where ego was, id must be.”

Federn stressed the fact that it is possible to establish transference with the part of the patient that has remained healthy, and strongly suggested that the therapist have a helper to be with the patient in the intervals between sessions. Fundamentally, in Federn’s method, the patient is guided to understand that a part of his ego is sick and that that part is not trustworthy.

Gertrude Schwing, a nurse who was analyzed by Federn, applied her analyst’s concepts to hospitalized patients. In a straightforward and honest but not fully convincing little book, A *Way to the Soul of the Mentally III,* she describes the schizophrenic as a person who has been deprived of the experience of having a real mother, one who loves her child at any cost. The psychiatric nurse must offer that love to the patient. She described several techniques that establish continuity of contact with the patient and stressed the point that the patient must have the feeling that this new mother is there and does not intend to abandon him. Schwing considers her treatment a preliminary one, to be followed by Federn’s method.

Hinsie is one of the American pioneers in the psychotherapy of schizophrenia. As early as 1930, he published a book devoted to this topic. He

studied patients in the adolescent period who voluntarily sought treatment, had insight into the fact that they were sick, and were communicative and willing to follow the directions of the therapist. Thus, Hinsie selected the easiest patients to treat. He relied predominantly on the clinical psychoanalytic method of "free association."

Eissler has stressed the importance of early psychotherapy during the acute episode. The way in which the case is handled at the beginning, he claims, often determines the whole course of the illness. He distinguishes the acute phase from "the phase of relative clinical muteness."

Wexler reported the successful treatment of a patient whom he treated by assuming the role of a tyrannical superego.

Bychowski has provided, in addition to important studies on schizophrenic thinking, important details on the manifestations, dynamics, and therapeutic handling of hostility.

Hill, again, emphasized the crucial role of the mother in the development of schizophrenia and gave details of technique in handling patients.

Within the Freudian school, noteworthy also are the contributions of Arlow and Brenner and Jacobson.

The ego psychologists of the Freudian school (Hartmann, Rapoport, and Hartmann, Kris, and Lowenstein) have acknowledged that schizophrenia is predominantly a disorder of the ego, but their practical impact on the psychotherapy of schizophrenia is not discernible so far.

The Kleinian School

The theories of Melanie Klein have been applied by many authors to the treatment of schizophrenia. According to Klein, very early in life the ego develops the capacity to introject and project as a defense against an overwhelming anxiety of annihilation. In the paranoid-schizoid position, which occurs during the first four or six months of life, anxiety is experienced as persecutory in nature. According to Rosenfeld, this way of experiencing anxiety contributes to certain defenses, "such as splitting off good and bad parts of the self and projecting them into objects which, through projective identification, become identified with these parts of the self." This process is the basis of narcissistic object relationships, which prevail in psychoses.

The fundamental point of view, advocated by Klein's pupils, Rosenfeld,' Segal, Bion, and early Winnicott, is that no modification in the classic Freudian psychoanalytic technique is needed in the treatment of psychotics. Winnicott later changed his views, and came to attribute great importance to environmental factors. Rosenfeld, Segal, and Bion have maintained adherence

to Kleinian theory and to the classic psychoanalytic technique. They continue to use the couch, to rely on free association and interpretation.

In 1954, Rosenfeld reported "that the psychotic manifestations attached themselves to the transference in both acute and chronic conditions, so that what might be called a transference psychosis develops." The concept of transference psychosis had already been introduced by Federn. But contrary to Federn, Rosenfeld felt that the transference psychosis should not be avoided, is indeed analyzable, and should be worked through by means of interpretation. In 1969, Rosenfeld described a number of projective identifications which occur in the treatment of psychotics. He stressed that it is essential to differentiate these projective parts of the self from the saner parts, which are less dominated by projective identification. These saner parts are in danger of submitting to the persuasion of the delusional self.

On the whole, the theory and methodology of the Kleinian school have received moderate acceptance in England but little acceptance in the United States. It is in South America, especially in Argentina, that they have attained the most prominent role among the various psychoanalytic orientations.

Methods Based on Participation in Patients' Vision of Reality

Some significant psychotherapeutic methods, although originated from quite different theoretical premises, have the common aim of making the

therapist enter and share the patient's vision of reality.

Rosen originated his method in 1943. At the suggestion of Federn, he called it "direct psychoanalysis." Whereas the usual or indirect psychoanalytic approach establishes communication with the patient through the ego, Rosen's treatment aims at communicating directly with the unconscious, presumably with the id, or with the "ego-states of infancy and childhood" (Federn). As we have already mentioned, Federn also thought that a transference psychosis may occur in the treatment of the psychotic, but whereas Federn felt that it had to be avoided, Rosen makes of it the major tool of therapy. In his early writings, Rosen described his technique without giving theoretical explanations. He gave abundant interpretations to the patient in a vivid and shocking language purported to reveal what Freud's early works attributed to the unconscious. Such explanations as, "You want to fuck your mother," or "You wish to kill your father," "You want to suck my cock" or "sleep with me," were quite frequent. The explanations were thus based on the concept of repressed sexuality, oedipal in origin.

Rosen believed also that the schizophrenic is the victim of a mother who had suffered from "a perversion of maternal love," and tried to offer to the patient what he did not have. The patient must experience in the therapist a powerful, protective, benevolent person, as he wished his mother would have been in his early childhood. The analyst must spend a long time with the

patient—up to sixteen hours a day—and, like Federn, must often resort to an assistant. The patient is showered or shocked with the interpretations, which explain the classic Freudian mechanisms. Such overwhelming, all-embracing treatment would often solve the acute episode in a few weeks and would have to be continued by the second stage of treatment, which follows a technique more similar to classic psychoanalysis.

During the treatment, the analyst enters the psychotic world of the patient, who immediately feels better because he is finally understood. The therapist should not even avoid becoming one of the imaginary persons who appear in the delusions. At times he assumes the role of the persecutor and tries to convince the patient that he will have a beneficial rather than a persecuting effect.

It is worthwhile to take a rapid look at Rosen's theories, developed after his first therapeutic efforts. After the first period of his therapeutic evolution, during which sexuality played the preponderant role, he developed the concept of "early maternal environment." According to Rosen, for the child "mother" equals "environment." "Mother" is an entity that includes not only the mother herself and what she does or fails to do in her maternal role, but also other people, what they do or fail to do. This concept of early maternal environment expands the concept of the "pervasion of the maternal instinct" in the etiology of schizophrenia. If this early maternal environment possesses

many negative qualities, it may become the chief cause of the disorder.

Another important concept of Rosen is his own modification of the Freudian superego. The superego is "the psychical representative" of the whole early maternal environment. The whole early maternal environment may be worse than the patient's parents. Rosen does not seem, however, to attribute any role to the child in experiencing the environment in a worse manner than it really is.[1]

Rosen's third important concept is, "You seek the mother you knew," that is, the individual unconsciously selects in his present environment the original characteristics of the early maternal environment. He tries consciously and unconsciously to make a mother out of anybody or anything in his surroundings. "His need for mother is so great that he continues to project maternal attributes upon persons or things which are manifestly not maternal in relation to him."

Rosen's fourth basic concept is that of transference, which is different from the classic Freudian concept. For Rosen, transference is a variety of the tendency to "seek the mother you knew." It is a "transformation of the nonmaternal into the maternal," a projection into the person the patient is involved with of the qualities and attributes he is seeking.

Whereas early in his career Rosen seemed to rely more on the shocking

effect of his interpretations, later he came to see the role of the therapist predominantly as one of "foster parent." The unit where the patient lives during the treatment is a foster home. There, the patient will find compensation for the inadequacies of the early maternal environment.

Rosen's method has been the object of much criticism. Even his early admirers pointed out the fragility of his theoretical framework when he had not yet developed his late theories. These admirers attributed his therapeutic successes to his personal qualities: lack of hostility, in spite of some apparently hostile attitudes, straightforwardness, perseverance, physical endurance, etc. Others felt that the interpretations he gave the patients were arbitrary, not even necessary, and that his success was due simply to the fact that he was able in some way to establish contact with the patient. Others doubted even his results. They stated that his claims of many recoveries were exaggerated; that some of his patients were misdiagnosed; that others who were undoubtedly schizophrenic had relapses and were later treated with physical therapies.

I, too, feel that Rosen's early assertions, like those of many pioneers, suffered from the enthusiasm of their advocate. Also, some of the theoretical bases of his techniques seem unsubstantiated. Nevertheless, it is beyond question that Rosen obtained at least temporary results and that he was able to inject enthusiasm into many workers at a time when the prevalent opinion

was that psychotherapy with schizophrenics was an impossibility.

In addition to Rosen's own works on the method of direct analysis are the writings by Brody, English et al., and Scheflen.

The Swiss psychologist Sechehaye also believed that the world of psychosis can be entered by the therapist with her method of "symbolic realization."' She accepted much of the classic psychoanalytic and existentialist approaches, but added many innovations. In her method, the actions and manifestations of the patient are not interpreted to him but *shared* with him. Of course, by resorting to his psychoanalytic training, knowledge of the patient's life history, and his own intuition, the therapist must in his own mind interpret what the patient experiences and means. Sechehaye's method aims at helping the patient to overcome the initial traumata of his life by offering him a level of interpersonal relations which is corrected and adjusted to the weak state of the psychotic ego. The patient is able to relive the unsolved conflicts of his early life and to solve them, or at least he becomes able to gratify some of his primitive needs. For instance, by giving her patient Renee apples (symbols of the maternal breast), Sechehaye allowed the patient to relive an early trauma and permitted a magical gratification of an oral need. Once the meaning of the patient's symbols is understood by the therapist, he uses them repeatedly in order to establish communication and also to transform reality to a level which the patient can

accept without being hurt or traumatized.

What Sechehaye tried to accomplish can be seen as the staging of a dream in waking life. As in dreams, symbols replace the objects which appear in the state of being awake. Gratification of primitive needs thus can take place. Sechehaye's method aims at entering the dream of the psychosis by creating an artificial and curative dream which eventually will lead to a healthy awakening.

Sechehaye's technique is difficult to practice. Is it possible in the majority of cases to set up an artificial dream which uses the symbols that belong only to a specific patient? A certain capacity for intuition is necessary, which manifests itself after contact is made with the inner core of the patient. Such capacity is not reducible to, or deducible from, rules or instructions or theoretical premises to be found in Sechehaye's method.

Laing's method is difficult to describe, because in spite of the author's many writings it has never been reported in the literature. In his first book, *The Divided Self,* he insists on examining the existential despair, the division of the patient's psyche, his "ontologic insecurity." In his later writings, Laing not only shares the psychotic world of the patient but embraces it. He feels that the patient is correct in blaming his family and the environment. He had to live in an unlivable situation; he really was persecuted, was labeled

"psychotic," dismissed from the human community. The method helps the patient to reassert and accept himself, and re-evaluate his position with the society in which he lives. Laing relies very much also on family therapy.

Frieda Fromm-Reichmann and Her School

In contrast with the three previous authors, Harry Stack Sullivan and Frieda Fromm-Reichmann tried to reach the patient not by entering or sharing the psychotic world but by remaining in the world of reality.

Sullivan is very well known for his theoretical innovations in psychiatry in general and schizophrenia in particular. People who have worked with him have attested to his therapeutic successes. Unfortunately, his premature death has prevented Sullivan from reporting in writing his technique. Mullahy has reported Sullivan's hospital therapy. Mullahy writes that Sullivan attempted a direct and thorough approach, chiefly by reconstructing the actual chronology of the psychosis. Sullivan impressed on the patient that whatever had befallen him was related to his life experience with a small number of people.

Fromm-Reichmann worked closely with Sullivan. Unlike him, she became better known for her therapeutic work than for her theoretical contributions. The value of her therapy received wide recognition. Fromm-Reichmann named her treatment "psychoanalytically oriented

psychotherapy," and not "psychoanalytic treatment," to emphasize that it constituted a departure from the classic Freudian psychoanalytic procedure.

Fromm-Reichmann's courage in treating difficult patients, the qualities of her personality—her genuine warmth, humility, and exquisite psychological intuition—certainly played an important role in establishing a milieu of therapeutic acceptance of the schizophrenic and in stimulating others toward similar pursuits. In addition to a very insightful book on psychotherapy, she wrote many papers, which have been collected and published by Bullard. Nevertheless, her basic ideas on the therapy of schizophrenia have never been integrated in a systematic whole, perhaps because of a lack of an original theoretical system. For theoretical foundations she leaned on Freud and to a larger extent on Sullivan. Sullivan's idea, that some degree of interpersonal relatedness is maintained throughout life by everyone, including the schizophrenic, was a basic prerequisite of her attempts to establish transference with the psychotic. Fromm-Reichmann stressed that it is very hard for the patient to trust anyone, even the therapist; and if the latter disappoints him in any way, the disappointment is experienced as a repetition of early traumas, and anger and intense hostility result.

Fromm-Reichmann treated the patient with daily sessions, did not make use of the couch or of the method of free association. She relied much less

than other authors on the therapeutic effect of interpretations. She made a cautious use of them, however, and emphasized that the symptomatology is susceptible of many interpretations, all correct, and that at times it is useful to give even partial interpretation.

Fromm-Reichmann was among the first to emphasize that the schizophrenic is not only alone in his world but also lonely. His loneliness has a long and sad history. Contrary to what many observers believe, the patient is not happy with his withdrawal, but is ready to resume interpersonal relations, provided he finds a person who is capable of removing that suspiciousness and distrust which originated with the first interpersonal relations and made him follow a solitary path. In order to establish an atmosphere of trust, the therapist must treat the patient with kindness, understanding, and consideration, but not with condescending or smothering attitudes as if he were a baby. Profession of love or of exaggerated friendship is also out of place. These would be considered by the patient bribery and exploitation of dependency attitudes.

Fromm-Reichmann tried to explain to the patient that his symptoms are ways of remodeling his life experiences in consequence of or in accordance with his thwarted past or present interpersonal relations. She wanted the patient to become aware of the losses he sustained early in life, but he must become aware of them on a realistic level. That is, he must not distort or

transform symbolically these losses, but must accept the fact that they can never be made up and that he is nevertheless capable of becoming integrated with the interpersonal world. It will be easier for him to integrate when he recognizes his fear of closeness and even more so his fear of his own hostility.

Fromm-Reichmann inspired many people, not only as a therapist but also as a teacher. Many of her pupils, although maintaining her general therapeutic orientation, have made important contributions. Prominent among them are Otto Will and Harold Searles.

Among Will's major points are his insistence that the therapist "define his relationship with his patient, refusing the patient's attempts to avoid such definition by his withdrawal or his insistence that he can never change, that there is nothing the matter, and that the therapist is of no significance to him." In addition to reporting vivid case presentations of patients treated in a hospital setting, Will has given useful instructions about what he calls "the development of relational bond" between the patient and the therapist. Such development requires (a) recurrent meetings of the participants, (b) contact of the participants with each other—verbal, visual, tactile, aural, etc., and (c) emotional arousal.

Searles has written many insightful papers, which have been collected in one volume. They make very rewarding reading, especially for some

aspects of the psychodynamics of schizophrenia and of the phenomenon of transference. Searles has described the difficulties of the transference situation: how the patient fights dependence that would compel him to give up fantasies of omnipotence. He has also shown how the transference situation leads the patient to additional projections. In an important paper, he clearly differentiates between concrete and metaphorical thinking in the recovering schizophrenic patient, although he makes no use of the studies done by other authors on this important subject.

Miscellaneous Contributions

Bowers applied hypnosis to the treatment of schizophrenia, although the general opinion is that such treatment is not suitable for psychotics. She hypothesizes that in hypnosis the therapist rapidly establishes contact "with the repressed, healthy core of the patient." She points out that the problems of resolution of the symbiotic relationship require the utmost skill, but long remissions have been secured. A successful hypnotized schizophrenic is moving toward recovery, as he is able to reincorporate the other, the therapist, and thus re-establish interpersonal relations.

Benedetti, an Italian psychiatrist who studied with Rosen and now teaches and practices in Switzerland, accepts a great deal of Sullivan and Fromm-Reichmann, as well as some existentialist concepts. He feels that the

two basic tools in the treatment of schizophrenics are sharing of the feeling of the patient and interpretation. Benedetti feels that high sensitivity, extraordinary need for love, and reactivity above the average level, make the patient very vulnerable to schizophrenia. The therapist must understand the request inherent in the suffering of the patient. The patient wants the therapist to understand his essence, his being the way he is, even if at the same time he rejects the therapist. Society, including therapists, tends to evade the patient's request by objectifying his symptoms and by not permitting him to make claims.

From an Adlerian point of view, Shulman has described very useful procedures. The therapist must help the patient to make a better rapprochement with life, to avoid the use of psychotic mechanisms, to change mistaken assumptions. In a very human and compassionate way, Shulman describes in specific details how to help the patient through these therapeutic procedures.

Psychotherapy in Practice

In the rest of this chapter an account will be given of psychotherapy of schizophrenics as practiced by the author. Much more extensive accounts of this technique, covering special situations and paradigmatic reports, are reported elsewhere. For didactic purposes, the author's approach can be

considered as consisting of four aspects: (1) establishment of relatedness; (2) treatment of the psychotic symptomatology; (3) psychodynamic analysis, that is, acquisition of awareness of unconscious motivation and insight into the origin and development of the disorder; (4) general participation in patient's life. We shall examine these four aspects separately, although they occur simultaneously in various degrees.

Establishment of Relatedness (Transference and Countertransference)

We must frankly acknowledge that, contrary to the other aspects of this type of therapy, establishment of relatedness is at a prescientific level of development. Szalita wrote that the therapist must still resort to a large extent to his own intuition. On the other hand, we should not be discouraged or exaggerate the difficulties of this treatment. Even the sickest patient can reacquire the wish to rejoin the human community, which is never completely extinguished. And yet, when we see the patient for the first time, he may have cut all human contacts or may retain only paranoid ties with the world. He feels unaccepted and unacceptable, afraid to communicate, and at times even unable to communicate, having lost the usual ways by which people express themselves. How can we break his isolation, aloneness, overcome the barrier of incommunicability, the uniqueness of his thought sequences?' The therapist's attitude must vary according to the condition of the patient. With patients who are in the prepsychotic panic or who have

already entered the psychosis and are acutely decompensating, we must assume an attitude of active and intense intervention. A sincere, strong, and healthy person enters the life of the patient and conveys a feeling of basic trust. From the very beginning, the therapist participates in the struggle which goes on; he does not listen passively to dissociated ideas. With his facial expression, gestures, voice, and attitude of informality and general demeanor, he must do whatever he can to remove the fear which is automatically aroused by the fact that a human being (the therapist) wants to establish contact.

In the confused, unstable, and fluctuating world of the patient, the therapist establishes himself as a person who emerges as a clear and distinct entity, somebody on whom the patient can sustain himself. The therapist must clarify his identity as an unsophisticated, straightforward, simple person who has no facade to put on, who can accept a state of nonunderstanding, who wants to help, though he may be the target of mistrust and hostility, and who has unconditional regard for the dignity of a human being, no matter what his predicament is. An atmosphere of reassurance is at least attempted, and the patient recognizes it. Clarifications are given immediately. The therapist enters the picture, not as an examiner who is going to dissect psychologically the patient, but as one who immediately participates in what seems an inaccessible situation. To a male patient in panic, I said, “You are afraid of me, of everybody, scared stiff. I am

not going to hurt you." To a woman who had given birth recently, I said, holding her hand, "You are going to be a good mother. I am here with you. I trust you."

These statements are "passing remarks" or "appropriate comments" and not detailed interpretations. They are formulations the therapist makes at once, during his first contacts with the patient. They must be given in short, incisive sentences. Their importance lies in conveying to the patient the feeling that somebody understands he is in trouble and feels with him. They should not be confused with deeper interpretations given later.

Some nonverbal, meaningful actions, such as touching the patient, holding his hand, walking together, etc., may be useful in several cases. The therapist must keep in mind, however, that this procedure may be dangerous with some patients. For instance, a catatonic stupor may be transformed into a frightening catatonic excitement.

This attitude of active intervention is not only not indicated in some acutely disintegrating cases, but can be harmful. It may be experienced as an intrusion, and even more than that, as an attack. The patient may be scared, withdraw, and disintegrate even more.

In these cases, we have to resort to an approach similar to the one used with patients who are withdrawn, or barricaded behind autistic detachment.

The therapist must be prepared to face negative attitudes and not to experience them as a rebuff. For instance, the withdrawn patient finds it unbearable to look at the therapist's face. He may close his eyes, or turn his face in a diametrically opposite direction. The therapist should not interpret this behavior as rejection of the treatment or of himself, but as ways to reduce to a less intolerable degree the frightening aspect of the interpersonal contact. If the patient is in an acute condition, frightened, and wanting to tell his troubles, the therapist must listen patiently and reassure him warmly. But if the patient does not desire to talk about himself or anything else, he should not be asked questions. Each question is experienced by the schizophrenic as an imposition, or an intrusion into his private life, and will increase his anxiety, his hostility, and his desire to desocialize. The request for information is often interpreted by the patient as "an attempt to take away something from him." Even the therapist seems to him "to take away," not to give. And yet we must convince him of our desire to give to him because he is so much in need.

This technique of not asking questions is a difficult one, especially for a therapist who has been trained in a hospital where patients must be legally committed. The administration of the hospital requires that information be collected directly from the patient which will show that the patient is psychotic and legally detained. The administration also requires a complete physical examination to exclude infective or other acute conditions. Of course,

these procedures are necessary, but I feel that the therapist should not carry them out. Perhaps, another physician could take care of these physical and legal requirements before the patient is assigned to a therapist. Although there may be some disadvantages to such a procedure and some physicians might resent the division of jobs, this is, as a rule, the best way to avoid the negative feelings that the patient would immediately develop for the therapist. Whenever it is possible, the contemporaneous treatment of a nonpsychotic member of the family (sibling or parent) can lead to a fuller understanding of the family constellation.

If the therapist is not supposed to ask questions of a reluctant patient, what is he to do? Again, various techniques are indicated according to the various cases:

1. It may be advisable for the therapist to take the initiative and talk about neutral subjects, conveying to the patient the feeling that a sincere effort is being made to reach him, without any strings attached.

2. If the patient is mute, almost mute, or catatonic, the therapist, expressing sympathy and a desire to break the incommunicability must talk to him. He must tell the patient that he (the therapist) realizes that the patient, though he feels and understands, is so frightened that he cannot talk. At times, however, it is better not to talk at all to the catatonic, if he seems to resent talking and withdraws more. The

therapist must then “share” a state of silence without being disturbed by it. Even a simple state of proximity without any talk may disclose to the sensitive therapist almost imperceptible ways of nonverbal communication which are specific for each patient and therefore impossible to report.

3. If the patient is very disturbed, or incoherent, and his speech consists of word-salad, the therapist should not pretend to understand him when he does not, but listen patiently. Soon, it will be realized that the word-salad, too, makes some sense. Some themes recur frequently, and the atmospheric quality of the patient’s preoccupations is transmitted.

4. At a more advanced stage of treatment, the patient will be able to talk more freely about himself and about his life. The gaps that still exist either in the knowledge of his life history or in the understanding of his production are often filled in easily by the therapist’s knowledge of the psychodynamics of schizophrenia and its formal mechanisms. The therapist must, however, always be alert to the possibility of uncommon and unpredictable dynamic and formal mechanisms.

5. If the patient is a verbose, apparently well-systematized paranoid who fanatically speaks about his delusions, an attempt must be made to detour his attention and re-establish his interest in the other aspects of life.

When the patient speaks to the therapist about his delusions and hallucinations, the latter must not pretend that he accepts them, but must

explain to the patient that there must be reasons why he sees or hears or interprets things in a different way.

There are many patients who present active psychotic symptoms, like hallucinations, delusions, or ideas of reference, but have no difficulty in communicating. The more preserved is the bulk of the personality of the patient, the more we can depart from the above recommendations. We may even ask questions and direct the patients to explain their obscure experiences. In these cases, too, the dialogue between the therapist and the patient should not be diagnostic or predominantly exploratory. The emphasis should be on giving and sharing. As a rule, free association, which was impossible with poorly communicating patients, should be discouraged with these relatively integrated patients, as it can promote scattering of thoughts. However, in some mildly psychotic patients free association can be occasionally resorted to when we feel that an attempt to repress important material is more dangerous than the risk of provoking regressive features.

There is a relatively large group of schizophrenics, especially those who had a prepsychotic stormy personality (see Chapter 24), with whom it is very easy to establish some contacts. These patients are hungry for contacts of any kind; they ask questions repeatedly and cling tenaciously to the therapist. The verbal contacts, however, are brittle. They consist of extremely anxious, superficial, and self-contradicting statements. The therapist should not try to

force these tenuous contacts to a breaking point. He should realize that at this stage the patient is capable of only this type of communication. The therapist should focus on a few issues which the patient is able to face.

What we have so far described demonstrates that we can indeed talk of transference and countertransference in the treatment of schizophrenics, but not in the same sense as in classic psychoanalysis. As we have seen in Chapter 24, the patient has never had a solid sense of basic trust, and after his break with reality, his mistrust reached gigantic proportions. The ferocious imprinting of early life and the resurgence of the primary process give monstrous shapes to whatever is experienced. The therapist, too, is part of a world of hostility, persecution, and desolation for the patient. In this world, it is easy to feel that it is better to have nothing, not even hope or any positive feeling for other human beings, because if you have them, you are bound to lose them.

The therapist must not fit into this world of unrelatedness, autism, distrust, and suspiciousness. It is by not fitting this world, by escaping from the category of malevolent forces, that the therapist will open a window, facing new, unfamiliar, but promising vistas.

The therapist must play what at first seems a dual and therefore difficult role: He must be a companion of the patient in his journey in the world of

unreality, and at the same time he must remain in the realm of a reality shared with the human community. If the therapeutic effort is successful, the distance between these two roles will decrease. With the methods to be described, the unreality of the patient will lose its uniqueness, because it will be partially shared by the therapist, at least emotionally, if not in its symbolic or cognitive elements. The patient will be more willing to return to reality if the anxiety caused by the realistic appreciation of his life's predicament is understood and shared by the therapist. In other words, an interpersonal tie must be established between therapist and patient, which I call *relatedness.* Relatedness includes transference and countertransference. It is the simultaneous occurrence, interplay, and merging of all the transferential and countertransferential feelings and attitudes. The feeling that the patient has for the therapist and the feeling that the therapist has for the patient, elicit other feelings about each other's feelings, in a self-perpetuating reciprocal situation. Although relatedness includes the classic psychoanalytic concept of object relation, it is not only a centrifugal force emanating from each of the two partners in the therapeutic situation, but also an interrelation between at least two persons, more an I-Thou relationship in Buber's sense, an entity whose intrapsychic and interpersonal parts could not exist without the other. At a theoretical level, the ideal goal of any psychotherapy would be the establishment of a state of communion among human beings, but this state is almost always impossible to achieve even among normal people. We must be

content with a state of relatedness where an exchange of trust, warmth, and desire to share and help exist.

The relatedness goes through several stages, which generally follow one another slowly and gradually, but in some cases rapidly and dramatically. From a state of autistic alienation the patient may pass into a state of genuine relatedness. This "breaking through" may be an extremely important episode, experienced at times with great intensity. In some instances, it is remembered by the patient with an emotional outlet reminiscent of the Freudian abreaction. However, "breaking through" in this context does not have the usual psychoanalytic meaning. It does not refer to the breaking of resistances and repressive forces, so that abreaction is possible and what was repressed is now remembered. It means only breaking the barrier of autism, the incommunicability, and the state of desocialization. A human bond between two persons who are important to each other is re-established. Although the therapist must avoid the mistakes the parent has made, the relationship must at first bear some resemblance to the parent-child relationship. Although the therapist, like the parent, is willing to give much more than he receives, a reciprocal concern develops. One fundamental point is that at the stage of treatment in which the establishment of relatedness is the primary goal, this relatedness must be *lived* by the patient as a new experience, and should not be taken into consideration as something to be psychodynamically interpreted, unless some complication necessitates doing this at once.

Transference and countertransference are obviously very important as objects of interpretation, but in this respect they must, as a rule, be examined later in the treatment.

Unfortunately, in a considerable number of cases, several and at times contradictory complications may jeopardize relatedness. We shall examine here the most common ones individually, although in several cases they occur in united forms. (For a more elaborated description of these complications, the reader is referred elsewhere.) The complications may necessitate an otherwise premature psychodynamic interpretation of the transferential situation. In many cases, the patient cannot stand too much closeness; he anticipates rejection and fears that rejection after so much closeness will be more painful, and he wants to be the one who rejects and hurts. These feelings are not fully conscious and put paranoid mechanisms into operation again. The patient tries to place the therapist, too, in the system of delusions, or will test him in many ways, in an attempt to prove that he, too, is not trustworthy. The mistrust may cover any aspect of the relatedness. Manifestations of warmth, interest, participation, sharing, may be viewed by the patient as having ulterior motives, as proofs of the therapist's intent to exploit the patient for heterosexual or homosexual gratification, or for purposes of experimentation, or in order to make a profit of some kind. Whenever tendencies of this type develop, they have to be corrected immediately, before they acquire a degree of strength which may jeopardize

the treatment.

Hostility is to be found sooner or later in every schizophrenic. Whenever possible, one should explain to the patient that the hostility is misdirected, and that he is acting as if situations that have long since disappeared were still in existence. When it has proven to be impossible to handle the hostility, the therapist may allow another person to be present at the interview. The patient will not resent this person as an intruder if he understands that this is being done to protect him, too, from the expression of his own hostility.

Some patients, once some elementary relatedness is established, develop an attitude of total dependency on the therapist. They act like babies, trying to reproduce the parasitic or symbiotic attitude they once had toward their mother. The patient must soon realize that the relationship with the therapist is not just a repetition of the old bond with mother, but a new type of close relationship. The new important person in the patient's life is a person who *cares* for him, not only *takes care* of him.

There is an additional type of transference the patient may develop, which also reveals a psychotic structure or understructure. The patient may develop "positive" feelings and concepts for the therapist which are so intense as to achieve unrealistically grandiose proportions and

characteristics. The therapist becomes omniscient, omnipotent, a genius, a prophet, a benefactor of the highest rank, a superb lover, etc. This type of relatedness is an exaggeration of the psychotic distortion that certain psychoneurotic patients experience. At times, it reaches comic proportions: The therapist is literally considered an angel or a divinity. The inexperienced therapist may, especially if the distortions are not too obviously psychotic, tolerate this relation and in some cases even receive from it narcissistic gratification.

It is possible to understand such an attitude, even if it is inappropriate. The therapist is the only person with whom the patient relates well; he is the only person who presently counts in the life of the patient, and therefore the only representative of what is good in the universe. If the therapist is of the opposite sex, a romantic element may enter and make the relation more intense. In spite of the fact that the intensity of feeling can be understood, the transferential relation is obviously abnormal. Primary-process cognition distorts the images the patient had once conceived of the good mother and of the ideal lover, and confuses them with the person of the therapist.

The proper procedure consists in correcting these distortions from the very beginning. The therapist must convey the feeling to the patient that he cares for him and that he is very important to him, even if his idealized position has to be dismantled.

We have so far discussed mainly that part of the relatedness which is usually called transference. The countertransference also plays a very important role in the psychotherapy of the schizophrenic. By countertransference we must not mean only identifying the patient with a figure of the therapist's past life or with the therapist himself as he was in his early life, although these identifications play a definite role. The therapist may experience an unusual motivation. Eissler felt that while he was treating schizophrenics his childhood fantasy of wanting to rescue people was reactivated. Rosen wrote that in the treatment of schizophrenics the countertransference must be similar to the feelings that a good parent would have for a highly disturbed child. Rosen expressed the idea extremely well when he said that the therapist must identify with the unhappy patient, as the good parent identifies with the unhappy child, and be so disturbed by the unhappiness of the patient that he himself cannot rest until the patient is at peace.

If, because of his own problems, the therapist identifies with the patient or even sees in the patient a psychotic transformation of his own problems, he may be helped in his therapeutic efforts rather than hindered.

At an advanced stage of treatment, the therapist loses the parent-like role. The two persons involved in the therapeutic situation become more like peers. We do not mean that they develop a relation similar to the one

generally occurring between two young schoolmates, but something reminiscent of the peer-relationship that good parents establish with their adult children.

We often read that termination of the treatment should occur only when the transference and the countertransference are solved. But, if with these terms we mean strong reciprocal feelings, transference and countertransference are hardly ever solved in the treatment of psychoses. The patient cannot cease to have positive feelings for his former therapist, just as a child does not cease to love his parents when he grows and does not need them any longer. Conversely, the therapist cannot forget a patient with whom he had such a long and close relation—a person with whom he shed "blood, sweat, and tears." Therapists remember with great pleasure the feeling of joy and the atmosphere of festivity created when former schizophrenic patients come to visit them years after the end of the treatment. Former psychotic patients never become index cards or collections of old data on yellowed medical records. They remain very much alive in the therapist's inner life to the end of his days.

Treatment of the Psychotic Symptomatology

Some therapists rely only on the establishment of relatedness in the treatment of schizophrenia, especially in very acute cases. The manifest

symptoms drop at times as soon as relatedness is established. In this author's experience, although loss of symptoms occurs in some cases, in the majority of cases the symptoms persist or return if the patient has not acquired insight into his psychological mechanisms, and has not changed his vision of himself, the others, life, and the world. Although psychodynamic interpretations are more widely known, interpretations concerning mechanisms and forms are also important, especially in an early phase of the treatment, and we shall devote most of this section to that topic.

Since Jung's formulations, schizophrenic symptoms have been compared to dreams of normal and neurotic persons, and have been interpreted similarly. However, whereas dreams are interpreted while the patient is awake and has reacquired the normal cognitive functions, the schizophrenic has to be treated while he is still in "the dream" of the psychosis.

In several writings, I have described in detail the technical procedures that I have devised to help the patient become aware of the ways in which he converts his psychodynamic conflicts into psychotic symptoms. Whereas the benefit from traditional interpretations is due, or believed to be due, to acquisition of insight into repressed experiences and to the accompanying abreaction, and therefore is supposed to be immediate, the effectiveness of the second type of interpretation consists in the acquisition of methods with

which the patient can work at his problems. It does not consist exclusively of insights passively received, but predominantly of tools with which the patient has to operate actively.

We shall discuss this type of treatment in regard to such symptoms as hallucinations, delusions, ideas of reference, and related manifestations. Before doing so, however, we must clarify some issues. Insistence on attacking the schizophrenic symptoms and not the foundations of the disorder may seem advocating only a symptomatic or secondary type of treatment. In the most serious psychiatric conditions, however, we find ourselves in unusual circumstances. The symptom is more than a symptom. Often, it is a maneuver that tends to make consensus with others impossible, or at least to maintain interpersonal distance. What may have originated as a defense makes the position of the patient more precarious and may enhance regression.

Secondly, the symptom, by building a symbolic barricade around the core of anxiety, does not permit us to touch the genuine anxiety. Let us take the typical example of the patient who has an olfactory hallucination: he smells a bad odor emanating from his body. On a deeper level, the patient feels he has a rotten personality; he “stinks” as a person. A schizophrenic process of concretization takes place and an olfactory hallucination results. The patient, by virtue of the symptoms, stops worrying about his personality

and worries only about his allegedly stinking body. As long as he talks only about the odor that emanates from him, he will not permit us to affect the focus of his anxiety.

But, if the symptom is needed to cover up or convert the anxiety, why do we want to remove it? Isn't removal of the symptom dangerous? It is dangerous unless we offer something in return which is more valuable. With the establishment of relatedness we offer a great deal to the patient: the realization that a person is there to share the uncovered anxiety and to make an attempt together with the patient to overcome it.

In this spirit of relatedness, the patient is now willing to adopt methods with which he can conquer his symptoms. We shall start with the treatment of hallucinations, which are perhaps the most typical schizophrenic symptoms.

Until recently, the opinion prevailed that incorrigibility was one of the fundamental characteristics of hallucinations. That is, until the symptom disappeared altogether, either through treatment or spontaneously, it would be impossible for the schizophrenic patient to become aware of the unreality of the phenomenon and to correct it. I have found that this is not necessarily so. Only auditory hallucinations will be taken into consideration here, but the same procedures could be applied to other types of hallucination after the

proper modifications have been made.

With the exception of patients who are at a very advanced state of the illness, or with whom no relatedness can be reached, it is possible to recognize that the hallucinatory voices occur only in particular situations, that is, *when the patient expects to hear them.*

For instance, a patient goes home, after a day's work, and expects the neighbors to talk about him. As soon as he expects to hear them, he hears them. In other words, he puts himself in what I have called *the listening attitude.*

If we have been able to establish not only contact but relatedness with the patient, he will be able under our direction to distinguish two stages: that of the listening attitude, and that of the hallucinatory experience. At first, he may protest vigorously and deny the existence of the two stages, but later he may make a little concession. He will say, "I happened to think that they would talk, and I proved to be right. They were really talking."

A few sessions later, however, another step forward will be made. The patient will be able to recognize and admit that there was a brief interval between the expectation of the voices and the voices themselves. He will still insist that this sequence is purely coincidental, but eventually he will see a connection between his putting himself into the listening attitude and his

actually hearing. Then, he will recognize that he puts himself into this attitude when he is in a particular situation or in a particular mood—for instance, in a mood that causes him to perceive hostility in the air, as it were. He has the feeling that everybody has a disparaging attitude toward him; he finds corroboration for this attitude of the others in hearing them making unpleasant remarks about him. At times, he feels inadequate and worthless, but he does not sustain this feeling for more than a fraction of a second. The self-condemnation almost automatically induces him to put himself into the listening attitude, and then he hears other people condemning him.

When the patient is able to recognize the relation between the mood and putting himself in the listening attitude, a great step has been accomplished. He will not see himself any longer as a passive agent, as the victim of a strange phenomenon or of persecutors, but as somebody who still has a great deal to do with what he experiences. Moreover, if he catches himself in the listening attitude, he has not yet descended to, or is not yet using, abnormal or paleologic ways of thinking from which it will be difficult to escape. He is still in the process of falling into the seductive trap of the world of psychosis, but may still resist the seduction.

I have found that if an atmosphere of relatedness and understanding has been established, patients learn with not too much difficulty to catch themselves in the act of putting themselves into the listening attitude at the

least disturbance, several times during the day. At times, although they recognize the phenomenon, they feel that it is almost an automatic mechanism, which they cannot prevent. Eventually, however, they will be able to control it more and more. Even then, however, there will be a tendency to resort again to the listening attitude and to the hallucinatory experiences in situations of stress. The therapist should never be tired of explaining the mechanism to the patient again and again, even when such explanation seems redundant. It is seldom redundant, as the symptoms may reacquire an almost irresistible attraction.

Now, that we have deprived the patient of his hallucinations, how will he be able to manage with his anxiety? How can we help him to bear his burden or a heavier but less unrealistic cross? An example will perhaps clarify this matter. A woman used to hear a hallucinatory voice calling her a prostitute. Now, with the method I have described, we have deprived her of this hallucination. Nevertheless, she experiences a feeling, almost an abstract feeling, coming from the external environment, of being discriminated against, considered inferior, looked upon as a bad woman, etc. She has almost the wish to crystallize or concretize again this feeling into a hallucination. If we leave her alone, she will hallucinate again. If we tell her that she projects into the environment her own feelings about herself, she may become infuriated. She says, “The voices I used to hear were telling me I am a bad woman, a prostitute, but I never had such a feeling about myself. I am a good

woman." The patient, of course, is right, because when she hears a disparaging voice, or when she is experiencing the vague feeling of being disparaged, she no longer has a disparaging opinion of herself. The projective mechanism saves her from self-disparagement. We must, instead, point out to the patient that there was one time when she had a bad opinion of herself. Even then, she did not think she was a prostitute but had a low self-esteem, such as she probably thought a prostitute would have about herself. In other words, we must try to re-enlarge the patient's psychotemporal field. As long as he attributes everything to the present, he cannot escape from the symptoms. Whereas the world of psychosis has only one temporal dimension —present— the world of reality has three—past, present, and future. Although at this point of the illness the patient already tends to live exclusively in the present, he retains a conception of the past, and such conception must be exploited. We direct the patient to face longitudinally his deep feeling of inadequacy. At the same time, the therapist with his general attitude, firm reassurance, and sincere interest, will be able to share the burden. At this point, the therapeutic assistant may be very useful.

What we said about hallucinations could be repeated with the proper modifications for ideas of reference and delusions. Before the delusions or ideas of reference are well formulated, the patient must learn to recognize that he is in what I call the *referential attitude.* Let us take the example of a patient who tells us that while he was in the subway he observed peculiar

faces, some gestures that some people made, an unusual crowd at a certain station, and how all this is part of a plot to kidnap and kill him. It is useless to reply to him that these are imaginary or false interpretations of certain occurrences. At this point, he is forced to believe that these events refer to him. We must, instead, help the patient to recapture the mood and attitude which he had prior to those experiences, that is, to become aware of his referential attitude. He will be able to remember that before he went into the subway, he looked for the evidence, he almost hoped to find it, because if he found that evidence, he would be able to explain the indefinite mood of being threatened that he was experiencing. He had the impelling need to transform a vague, huge menace into a concrete threat. The vague menace is the anxiety of the interpersonal world, which, in one way or another, constantly reaffirms the failure of his life.

The patient is then made aware of his tendency to concretize the vague threat. The feelings of hostility and inadequacy he experienced before the onset of the psychosis have become concretized, not to the point of becoming hallucinations, but to the point of delusions, or ideas of reference. No longer does the patient feel surrounded by an abstract world-wide hostility. It is no longer the whole world that considers him a failure; now “they” are against him, “they” call him a failure, a homosexual, a spy. This concretization is gradual. The “they” obviously refers to some human beings who are not better defined.

Not only do we make the patient aware of his referential and delusional attitude, but also of his concretizing attitude. In other words, although the delusions and referential thoughts are symbolic, at this stage of treatment we avoid complicated explanations of symbols. Instead, we help the patient to become aware of his own concretizing, of substituting some ideas and feelings for others that are easier to cope with. For instance, the patient will be helped to recognize that it is easier for him to think that his wife poisons his food than to think she poisons his life. He may also recognize that the feeling he has that some people control his thoughts is a reactivation and concretization of the way he once felt that his parents were controlling or trying to direct his life and his way of thinking. If relatedness is achieved, the patient becomes gradually aware of the almost incessant process of converting the abstract part of his life into concrete representations.

Some of this active concretizing may be difficult for some patients to understand, especially in some manifestations. However, a large number of patients will eventually understand it with great benefit. One of the most obscure and yet most important manifestations of this process of concretization is a phenomenon that has baffled not only patients but psychiatrists as well. A patient happens to think, let us say, that dead relatives are coming to visit him in the hospital. As soon as such thought occurs, it becomes a reality! He believes that the relatives are already there in the hospital. Thoughts are immediately translated into the real facts they

represent, just as in hallucinations and dreams they are transformed into perceptions. A thought that represents a possibility cannot be sustained. Schizophrenics are still capable of conceiving and even sustaining thoughts of possibilities when they do not involve their complexes. However, possibilities concerning anxiety-provoking situations are conceived but not sustained for a long time: They are translated into actuality.

The patient is made aware of this tendency, and although at the beginning of the treatment he may not be able to arrest the process, he becomes familiar with what he himself is doing to bring about the delusional world.

The concretizing attitude is expressed not only by ideas and delusions, but also by bizarre behavior. Some patients always stand close to a wall, away from the center of the room. The habit is so common and so well known that we are not liable to make a mistake if we say to the patient, "You want the wall to protect you from the threatening feelings you sense all around. I am here with you. Nothing will attack us. Nothing will injure us. We need no walls. Let's walk together."

To some patients who injure themselves to substitute a physical pain for an emotional one, we may say, "you want to hurt yourself to remove your anguish. If you talk to me about it, we may share the anguish; the pain may

diminish." This explanation has to be given with some caution, because self-injury is not always an attempted concretization of mental pain. At other times, it is exclusively or predominantly an expression of need for punishment, or a way to achieve change in gender, or bodily disfigurations that have a symbolic meaning.

A frequent symptom is screaming, at times occurring abruptly, loudly, and in a terrifying manner. Screaming is a way of expressing sorrow, powerlessness, and protest in a way more primitive than even the crying of the sufferer. Crying, as a baby would do, has an appealing quality, which the scream does not possess. The patient feels he cannot appeal to anybody. His life-long whimpering was never heard, and he must scream now. But the therapist must perceive the scream as a lifetime of whimpering and suffering in desolate solitude. He must let the patient know that he has received the message and is ready to answer it.

Different, although related, is the apparently inappropriate hebephrenic smile or, less frequently, the almost spasmodic laughter. The patient laughs at it all, or laughs the world off. The trouble is too big, too lurid; not Only must you keep distance, not only must you have nothing to do with it, but you must laugh at it. The therapist must receive the hebephrenic message of defiance and rejection of the world, and help him to find at least a small part of this big world at which he does not need to laugh.

All interpretations discussed in this section require a knowledge of the abnormal cognition of the schizophrenic. The therapist must be able to recognize the special thinking and logic used by the patient and explain it to him. However, if the patient is very regressed, he will not benefit from any direct explanation. There are, however, some abnormal ways of thinking which are not too dissimilar from those of the normal person and can be easily explained.

Many other techniques, such as the acquisition of punctiform insight, cannot be reported here for lack of space, and the reader is referred to other writings.

Psychodynamic Analysis

Psychodynamic treatment aims at the acquisition on the part of the patient of awareness of his unconscious motivation and of insight into the psychological components of the disorder.

Psychodynamic treatment starts at the beginning of therapy but expands when relatedness has been established and at least some of the prevailing psychotic mechanisms have abated or disappeared. Contrary to what is believed by many, schizophrenics have no insight into the psychodynamic meaning of most of their symptoms. Interpretations are thus necessary when patients are ready to accept them.

A detailed analysis of psychodynamic therapy would require repetition of a great part of the substance of Chapter 24. We shall focus here on some of the fundamental points. In the beginning of treatment, the parental role is generally shifted in a distorted way to the persecutors. In a minority of cases, it is shifted not to persecutors, but to supernatural, royal, or divine benefactors who, in these grandiose delusions, represent figures antithetical to the parents. When the patient re-establishes relatedness and discovers the importance of childhood and his relations with his parents, he goes through another stage. The original parental image comes to the surface and he attributes to the parents full responsibility for his illness and despair. As we have seen in Chapter 24, even many analysts and psychiatrists accept these explanations given by patients as real insights and as accurate accounts of historical events. It is easy to believe in the accuracy of the patients' accounts, first of all because some parents seem to fit this non-parental image; secondly, because the patients who have shifted their target from persecutors to parents have made considerable improvement, are no longer delusional or only to a minimal degree, and seem to a large extent reliable. The therapist must be careful. In a minority of cases, the parents have really been as the patient has depicted them, but in by far the great majority of cases, the patient who comes to recognize a role played by his parents exaggerates and deforms that role. He is not able to see his own deformations until the therapist points them out to him. Fortunately, some circumstances may help. In this newly

developed anti-parental zeal, the patient goes on a campaign to distort even what the parent does and says *now.* Incidentally, this tendency is present not only in schizophrenics, but also in some pre-schizophrenics who never become full-fledged psychotics. By being fixated in an anti-parental frame of reference they may not need to become delusional and psychotic. To a much less unrealistic extent, this tendency occurs in some neurotics, too. At times, the anti-parental campaign is enlarged to include parents-in-law and other people who have a quasi-parental role.

The therapist has to help in many ways. First, he points out how the patient distorts or exaggerates. For instance, a white lie by the parent is transformed into the worst mendacity, tactlessness into falsity or perversion. These deformations are caused by the need to reproduce a pattern established in childhood, a pattern that was the result of not only what historically happened but also of the patient's immaturity, ignorance, and misperception. At times, these deformations are easy to correct. For instance, once the mother of a patient told her, "Your mother-in-law is sick." The patient interpreted her mother's words to mean, "With your perverse qualities you have made your mother-in-law sick, as you made me sick once." On still another occasion, the mother spoke about the beautiful apartment that the patient's newly married younger sister had just furnished. The patient who, incidentally, was jealous of the mother's attention to her sister, interpreted this remark as meaning, "Your sister has much better taste than

you." The patient must be brought to realize that the negative traits of parents or other important people are not necessarily arrows or weapons used purposely to hurt the patient. They are merely characteristics of these people and should not be considered qualities involving the total personality.

For instance, there might have been some elements of hostility in the remarks of the mother of the patient, which we have just reported. In every human relation and communication, in every social event, there are many dimensions and meanings, not only in the so-called double-bind talk of the so-called schizophrenogenic mother. But the patient focuses on this negative trend or aspect, and neglects all the other dimensions of the rich and multifaceted communication. The patient is unable to tolerate any ambivalence, any plurality of dimensions.

Most importantly, the original parental introject must lose importance. The patient is an adult now; it is up to the patient to provide for himself or to search out for himself what once he expected to get from his parents.

Whereas at an earlier stage of treatment relatedness (with its transference and countertransference components) was a lived experience, at a more advanced stage of therapy it becomes one of the main objects of interpretation. Whereas earlier in life the patient molded his relations with the world according to a deformed pattern established with the parents or

other people, now he has to revise these relations because of the influence of the transferential pattern. Interpretations lead the patient to understand the need for old patterns in his past life and for new ways now.

As we have already mentioned, the general attitude of the therapist will change gradually from one that could be called maternal to one that is paternal at first and later a peer-relation.

Two possible types of countertransference must be recognized and combated. The therapist may have become so used to treating the patient that he is not aware of his improvement. The other type of countertransference is almost the opposite. The therapist has become so familiar with the patient's ways that he no longer recognizes the patient's pathology as such, especially if he has a strong liking for him. He may consider the patient improved when he is not.

Unless the patient changes his self-image, he is not likely to lose his psychosis or potentiality for psychosis. Some symptoms which are generally very resistant to treatment and persist even after long therapy are dysmorphophobic delusions, such as the feeling of being very little or deformed, having changed the aspect of one's face, one's head having become flat or empty. These delusions are concrete representations of the distorted image of one's personality. The self-image is so unacceptable to the patient

that he does not want to reveal it. When these dysmorphophobic delusions and hallucinations have been lost, the patient has to face what he thinks of himself as a person, not as a body. But now, as we have already mentioned, he will know that the anxiety caused by this confrontation with himself will be shared by the therapist. Moreover, the patient knows by now that his human dignity has been recognized by the therapist, that he is not a specimen in an insane asylum. The therapist has become his peer; the therapist shares values with him.

The therapist eventually makes it clear to the patient that his difficulty to adapt to the environment is not necessarily a negative characteristic from a moral point of view, even if it is from the point of view of practicality and comfort. Normality, or what we call normality, may require mental mechanisms and attitudes that are not so positive or admirable from a point of view that transcends adjustment. Often, what is demanded of the normal person is callousness to noxious stimuli. Normal people protect themselves by denying these stimuli, by hiding them, becoming insensitive, or finding a thousand ways of rationalizing them or adjusting to them. By being so vulnerable and so sensitive the patient may teach us to counteract our callousness, to strive to become the sovereigns of our own will.

Interpretation of dreams plays an important role also in the psychotherapy of schizophrenia. As a rule of thumb, we may say that

schizophrenics and nonschizophrenics differ much less in their dreams than in their waking life. However, if we examine a large number of dreams of schizophrenics, we may recognize the following characteristics (valid only statistically, but not necessarily for a single dream):

1. The element of bizarreness is more pronounced.

2. Secondary-process mechanisms hide the latent content less.

3. There is often an element of despair or a crescendo of anxiety, with no resolution.

For other studies of dreams of schizophrenics see Noble, Kant, Richardson and Moore, and Arieti.'

General Participation in Patient's Life

The treatment of the schizophrenic cannot consist only of the sessions, but an active participation in his life is necessary.

When the patient is very sick and his requirements are immense, I have resorted to the help of a therapeutic assistant. A psychiatrically trained nurse or a former patient, when a nurse cannot be found, are the best qualified to act as therapeutic assistants. Federn and Rosen were the first to report this procedure. If the patient is hospitalized, a nurse assigned especially to him may be very useful to the patient when the latter is not in session with the

therapist. A former patient who has been successfully treated and has a fresh memory of the experiences he went through may have a feeling of empathy and understanding difficult to match.

It is particularly at a certain stage of the treatment that the therapeutic assistant is valuable. When the patient has lost concrete delusions and hallucinations, he may nevertheless retain a vague feeling of being threatened, which is abstract, diffuse, and from which he tries to defend himself by withdrawing. The assistant is there to dispel that feeling. That common exploration of the inner life in which the patient and therapist are engaged is now complemented by an exploration of the external life, made together with the therapeutic assistant. The therapeutic assistant helps the patient to decrease his fears in the act of living. Peplau' thinks that the nurse (or attendant) can accomplish that by establishing a feeling of “thereness.” (For many details concerning the relation between the patient and the therapeutic assistant, the reader is referred elsewhere.)

At this stage, the patient wants tasks to be given to him and demands to be made on him contrary to the way he felt at the beginning of the treatment. By fulfilling these tasks, the patient will make gains in self-evaluation.

Advanced Stage of Treatment

At an advanced stage of treatment, the patient becomes increasingly

similar to a neurotic patient. The therapist should not be overly impressed with the change and should remember that the recovering psychotic always remains more vulnerable and unstable than the neurotic and that some relapses are liable to occur. Conversely, if minor relapses occur, the therapist should not feel unduly discouraged. Their occurrence and their relative mildness in comparison to the initial stages of the illness should be explained to the patient and his family in reassuring terms.

One of the difficulties encountered at a late stage of treatment is fear of improvement. This fear may be caused by many factors. One of the most common is the fear of having to face life again and not succeeding. Being healthy implies responsibility. Again, the fear of life should be analyzed and reduced to normal proportions.

In other cases, in the process of reassuring himself the patient may re-experience that feeling which tormented him in his prepsychotic stage, when he thought that to be himself meant to be odd, and that therefore it was advisable for him to be as others wanted him to be. Actually, this feeling will not last a long time because the patient has learned to accept himself as a person in his own right.

For the handling of the patient in case of separation from his family, the reader is referred to other writings.

Several important complications may occur at an advanced stage of treatment. We shall mention here only one: the occurrence of depression, while the patient is improving from schizophrenic symptoms. At times, the reason for the depression is a relatively simple one. By losing the symptoms, especially of the paranoid type, the patient is deprived of something that he may consider valuable. Although manifestations of pathology, the symptoms permitted a certain tie or involvement with the world. Now, the patient feels he has sustained a loss, is empty, more alone and lonely than before. However, the recovering schizophrenic often feels depressed on account of a much more complicated mechanism. When he was paranoid, he projected the bad image of himself to the external world. The persecutors were accusing him, but he felt he was an innocent victim, and his self-esteem apparently benefited. When, as a result of treatment, he is deprived of these paranoid mechanisms, he may tend to re-introject the bad image of himself, to consider himself worthless, guilty, and consequently feels depressed. Generally, in these cases tendencies toward retention of a bad self-image and strong depressive overtones existed even before the psychosis started, but when the psychosis occurred, schizophrenic projective mechanisms prevailed. The self-accusing tendencies have to be analyzed, discussed, traced to their origin, and corrected.

Another idea that may bring about depression or discourage the patient from improving is the thought of getting well for somebody else's sake, not

for his own. The idea of submitting again to others, or to the world, is not appealing to the patient. This feeling also will be temporary if the patient now accepts himself and has learned to assert himself.

Criteria for Termination—Concept of Cure

Psychotherapy of the psychotic involves many important considerations, and the reader is again referred elsewhere for such important topics as precautionary measures, legal responsibilities, relations of the therapist with the family of the patient, and rehabilitation of the former psychotic.

When can a patient be considered ready for termination? Loss of symptoms is not enough. End of treatment has to be considered when the patient has modified his self-image, his vision of life and of the world. Self-identity must be more definable and awareness of inner worth must have increased. Reality must be experienced as less frightening and less impinging. The patient no longer experiences a sense of passivity, that is, he does not see himself any longer purely as the object of fate, chance, nature, persecutors, spouse, parents, children, etc., but as somebody who thinks and acts as independently as the other members of society do. He must have succeeded in maintaining an active and satisfactory role in his work, interpersonal relations in general, and intimacy.

Is schizophrenia curable? Before attempting an answer we must define the word "cure." Traditional medicine considered cure a *restitutio ad integrum* or to the *statu quo ante,* that is, a return to the state that existed prior to the onset of the illness. The concept loses some of its significance in psychiatry because in many psychiatric conditions the so-called premorbid state was already morbid and very much related to the subsequent condition. If by cure we mean simply loss of manifest schizophrenic symptomology, the answer is definitely yes. But we have already seen that no psychotherapist should be satisfied with this type of recovery.

If by cure we mean the return to the premorbid state or to an equivalent condition, the answer is still yes. But, again, we cannot be satisfied with a return to a prepsychotic personality. If by cure we mean the re-establishment of relatedness with others, satisfactory intimacy with a few human beings, and reorganization of the personality, which includes a definite self-identity, a feeling of fulfillment or of purpose and hope—and this is the cure we want—in my opinion the answer is still yes. In my experience, we can obtain these results in a considerable number of cases. As a result of psychotherapy, many patients have achieved a degree of psychological maturity far superior to the one that existed prior to the illness.

If by cure we mean a state of immunity, with no possibility of recurrence later in life, my reply is that we are not yet in a position to give an

absolute guarantee. Not enough years have passed since intensive psychotherapy has been applied to schizophrenia and the cases are not yet so numerous as to permit reliable statistics.

In reviewing the cases that have been treated satisfactorily with intensive psychotherapy, I have come to the conclusion that my optimistic predictions of no recurrence proved to be accurate in the great majority of cases, but not in all. To my regret, I remember patients whom I treated to a degree that I deemed satisfactory and who nevertheless had relapses. I must stress, however, that in most of these cases the relapses were moderate in intensity and the patients promptly recovered.

In cases in which we cannot obtain a complete cure, we nevertheless achieve a level of living where social relations, conjugal rapport, and work activities are possible to a level matching or surpassing the one prevailing prior to the psychosis. In some less successful cases, the patients learned to recognize situations to which they were vulnerable. By avoiding them, they were able to live an acceptable life.

Many patients whom I consider cured have achieved important positions and a maturity in their personal life that would have been difficult to envision and predict in people who were so ill.

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Notes

1 In this connection, see Arieti, and also Chapter 24 of this volume.