

THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

PSYCHOTHERAPY WITH SCHIZOPHRENIC PATIENTS

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Psychotherapy with Schizophrenic Patients

The treatment of schizophrenics belongs to the category of unpredictables. The same method of treatment may fail in one case and succeed in another. An experienced therapist may fail with a patient with whom a beginner may succeed. Diametrically opposed philosophies claim good results. Some authors even believe in recovery without treatment.

Classic psychoanalysis is not the choice treatment of schizophrenia. The reclining position and the psychoanalyst's spare comments are likely to increase anxiety in the patient and facilitate regression. Even Freudians, such as Bychowski, Brody, Eissler, Federn, Knight, Rosen and Wolman deviate from Freud's techniques when they treat schizophrenics. Thus the gulf between Freudians and non-Freudians such as Sullivan, Fromm-Reichmann, and Arieti has been reduced. Today both groups emphasize face-to-face relations as essential for a successful treatment.

Encouraging psychotic patients to associate freely is strictly contraindicated, since "free association induces and increases disintegrated thinking." Melanie Klein and her school interpret unconscious processes in treating schizophrenics. But Eissler in discussing Rosen's direct interpretation says, "another set of interpretations might have achieved a similar result." An evaluation of Rosen's methods did not prove that his interpretations were specifically helpful.

It seems that successful therapists proceed in a similar way notwithstanding semantic differences in their reports. Federn was most successful with patients he took into his home. J. N. Rosen writes

In order to treat the schizophrenic, the physician must have such a degree of inner security that he is able to function independently, whether he is loved by the patient or not. . . . He must make up for the tremendous deficit of love experienced in the patient's life. Some people have this capacity for loving as a divine gift.

Arieti stressed the necessity to give the patient the feeling "that he has been given something" without demands. Redlich finds that all the methods being reviewed reflect the "eternal common sense methods of love and patience." This common element in the various therapeutic techniques, despite their theoretical differences, has inspired the developments of the method of interactional psychotherapy with schizophrenics.

I start from a brief description of schizophrenic dynamics and etiology. Since there is no agreement on what schizophrenia is, I can only say what I believe its true nature to be. I believe schizophrenia is a socio-psychosomatic disorder caused by disturbed interactional patterns. The noxious interactional patterns affect behavior and personality structure and, in turn, cause organic disorders; thus, the socio-psychosomatic chain.

An individual becomes schizophrenic through morbid involvement with other individuals, usually parents or parental substitutes, and the disorder

severely affects his interaction with others. A schizophrenic may be more schizophrenic with some people than with others.

My theoretical frame of reference is a modified Freudian model. While Sullivan's emphasis on interpersonal relations has been invaluable, I see no reason to abandon Freud's personality model. The need to include inter-individual relations dictates some modifications in Freud's theory. A new theoretical construct, "inter-individual cathexis," revises Freud's pleasure and pain theory, and a new interpretation of the role of hate and destructive impulses in mental disorders is offered.

Interaction patterns are divided into instrumental (take), mutual (give and take) and vectorial (give) types of interaction. In normal families, parent versus parent relationship is mutual; parent versus child, vectorial; and child versus parent, instrumental.

In families with schizophrenic offspring, parent-parent relationship is hostile-instrumental; mother-child attitude is pseudo-vectorial, but actually exploitative-instrumental; father-child relationship is frankly instrumental in a seductive or competitive fashion.

The pre-schizophrenic starts his life as any other newborn child in a state of primary narcissism with all his libido invested in himself and all his destrudo (aggressive energy) ready to be directed against threatening

objects. In a normal development, the loving and protecting (vectorial) parental attitude enables the child to grow and develop normal instrumental, mutual and vectorial attitudes. The pre-schizophrenic child, however, realizes that his parents are not protective and that, therefore, unless he protects them, he may lose them. The schizophrenic paradox reads as follows: "I want to live, but I must sacrifice my own life to protect those upon whom my survival depends." This attitude leads to an abundant, hyper-vectorial cathexis of the child's libido in his parents and extreme efforts on his part to inhibit his self-protective outbursts of destrudo directed against those whom he must protect at his own expense. The schizophrenic fears that his inadequate love of parents and loss of control over his own hostility may kill them and then he will be lost forever.

Schizophrenia can be viewed as an *irrational struggle for survival*. The fear of losing the love object forces the individual to care more for the object than he does for himself. This hyper-vectorial object cathexis reduces the individual's own resources and prevents adequate self-cathexis. When the shrinking amount of libido left for self-cathexis is unable to protect the individual, the destrudo takes over.

The toilet training stage is the one during which the normal child develops a sense of mutuality. Feces are the first indisputable possession of the child, and toilet training introduces the first gift-giving relationship and

the first sacrifice. The child learns to postpone immediate satisfaction for a future gratification derived from delayed elimination and maternal approval.

The pre-schizophrenic, however, never receives whole-hearted approval, for no matter what he gives, it is not enough. His efforts do not satisfy his mother, and his true or alleged imperfections are held responsible for the mother's true or imaginary ailments. Thus, he continually feels that he must strive harder in his efforts to love and protect her.

The pre-schizophrenic learns early to sacrifice his *pleasure principle* without obtaining an adequate *reality principle*. Normally, the infant learns to postpone immediate gratification and pleasure for a future, a better and a less threatening one. This is the reality principle. But the *pre-schizophrenic is forced to renounce his pleasure principle without any further compensation*. He is forced to sacrifice his own needs for those of others and pushed into a hyper-vectorial position.

This self-hypocathexis is often disastrous for the individual, and one of the impending signs of this disaster is the breaking through of destrudo. It is here assumed that libido and destrudo are two types of the same mental energy and are mutually transferable. Libido is the higher, destrudo the lower energy, and when libido fails in serving survival, destrudo takes over.

In brief, there are three main causes precipitating outbursts of hostility.

When the individual supply of *libido is exhausted*, he becomes hostile in an effort to protect himself. Hostility is also provoked when the individual's *hyper-vectorial libidinal cathexes are turned down* by his love object. Finally, in an effort to protect himself from the devastating effect of his self-directed hostility in the form of guilt and self-recrimination, the individual may *project* his hostility against others. Yet outbursts of hostility represent a threat to the individual's parental pseudo-protectors, and thus the fear of his own destructive power forms an important theme of the schizophrenic's preoccupations and, in some cases, hallucinations.

These abnormal interactional patterns represent a disbalances in inter-individual cathexes. A child, normally "a taker" (instrumental), is forced into precocious giving (hyper-vectorial). Hence *vectoriasis praecox* is the proposed name for schizophrenia.

Several workers describe "schizo-genic" mothers as narcissistic, cold and demanding, but there is no real agreement on the pathology of mothers or fathers of schizophrenics. Alanan found 10 percent of the mothers and 5 percent of the fathers to be schizophrenic. I have found about 40 percent of fathers and 50 percent of mothers displaying a great variety of pathological conditions, but not any one particular type of disorder.

Lidz and associates discovered peculiar interaction between the parents

of schizophrenics. “We realized soon, that the intrapsychic disturbances of the mothers were not nearly as relevant . . . as was the fact that these women were paired with husbands who would either acquiesce to their many irrational and bizarre notions of how the family should be run, or would constantly battle and undermine an already anxious and insecure mother.” Similar findings have been reported by Wolman, Lu, and others: “The etiology of schizophrenia requires the failure of the father to assume his masculine controlling function.... To produce schizophrenia, it appears necessary for the mother to assume the father’s role.” “The mother, the over-adequate one in relation to the inadequate child, is in charge of the child. . . . The father is then in the functioning position of a substitute mother.”

It is not the “weak father and strong mother” that produce schizophrenia in their offspring. Were this so, *all* siblings of a schizophrenic would be schizophrenic also. Also observations of families of manic-depressives point to several cases of domineering mothers and submissive fathers. It is *the frustrated instrumentalism in interparental relationship that causes schizophrenia*. A woman who married hoping for an ideal father hates her husband and uses the child as an emotional substitute. The man who married a woman hoping she would become his mother is frustrated and tries to compete with or seduce his own child. These mothers cannot tolerate the child’s growth toward independence. They demand an unlimited love, appreciation and never-ending gratitude.

The normal reaction of a child to this emotional extortion should be hatred, but the avenues of hate are blocked. Mother convinces the child that she protects him, and the child begins to hate himself for having hostile feelings toward his self-sacrificing mother.

As suggested earlier, schizophrenia develops as a paradoxical action of an organism that abandons its own protection to protect those who should protect it. The disbalances in inter-individual cathexes leads to a severe disbalances in intra-individual cathexes of libido and destrudo. These psychological changes affect the nervous system, endocrine and other organic processes. Most somatic symptoms in schizophrenia are psychosomatic; however, schizophrenics, as all other people, may develop physical diseases. Their inadequate self-cathexis may make them more prone to succumb to physical disease and most schizophrenics suffer from a variety of physical illnesses.

PROGNOSIS

Kraepelin believed that only 4 percent of schizophrenics completely recover. The fact that about half of all inmates of mental hospitals are schizophrenics while only one-fourth of admissions are schizophrenics speaks for a poor prognosis.

It is my conviction that *schizophrenia is incurable only when there is no*

one willing and capable of curing the schizophrenic. Each schizophrenic requires a great deal of consideration, patience, understanding and prolonged vectorial relationship. The amount of individual care, emotional investment and therapeutic skill necessary for the cure of one schizophrenic is tremendous. Small wonder most schizophrenics are neglected.

The alleged “spontaneous recovery” cases are probably patients who evoked interest and sympathy in the staff and have received a scientific or intuitive, planned or unplanned, psychotherapy given to them by a vectorially minded individual.

The therapeutic interaction with schizophrenics is full of hazards. A schizophrenic may fear to ask for love or be frightened whenever it is offered. If he is still capable of accepting affection, he may clutch to the giver and become possessive and over-demanding. The schizophrenic’s vehement love and violent hatred represent a serious challenge even to an experienced psychotherapist. Schizophrenics often put exaggerated demands on the time and work of their therapist. One patient used to telephone the therapist several times a day and at odd hours of the night. Another patient refused to eat unless “her doctor” would feed her.

Another patient insisted on seeing his doctor any time he felt the need to see him, irrespective of the doctor’s obligations toward other patients.

Thus, many psychotherapists become impatient and disappointed in their work.

Thus, only a *field-theoretical* approach which includes the patient, the therapist and other environmental factors permits prognostic judgment. The attitude of the therapist to the patient and the patient to the therapist is not the only prognostic factor but certainly the most important one.

THE THERAPEUTIC GOAL

The main aim of the interactional psychotherapy is the reversal of libido cathexes with a resultant reorganization of personality structure.

Many psychotherapists who otherwise differed from each other have a vectorial, unconditionally giving attitude. It is a helping, giving attitude irrespective of the friendly or hostile reactions of the one who receives (just as good parents love good and bad children alike).

Even untrained individuals have been successful in treating schizophrenics. When a friendly person shows interest and a desire to help, this vectorial attitude helps the schizophrenic patient to improve the balance of libido cathexes. A visit of an old friend who comes to the hospital and shows affection may produce miracles and cause remission. Freudian, Adlerian, Jungian, Sullivanian and Horneyan psychotherapists can be

successful in the treatment of schizophrenics; apparently the differences between all these theories are not significant for the treatment. What is significant is *common* to all successful therapists regardless of their philosophies.

But this is more than “common sense, love and patience.” A successful psychotherapy is a distinct interactional pattern aiming at the restoration of intra-individual balance of cathexes and realistic perception of life. A detailed description of the interactional rules follows.

Rules of Therapeutic Interaction

The first rule is *unconditional support*, protecting the patient’s self-esteem by siding with him, by accepting him as an individual, by treating him in a dignified and respectful manner. A genuinely friendly attitude and atmosphere are a *conditio sine qua non*. The therapist must encourage adult (never regressive) pleasure-procuring activities. An unreserved yet rational support is necessary to counteract the process of regression and downward adjustment.

The second rule is *ego therapy*. The main aim of interactional psychotherapy is to strengthen the patient’s ego. In neurosis the ego is struggling against undue pressures from within; the *ego-protective*, neurotic symptoms bear witness to the struggle. In psychosis the ego has lost the

battle and psychotic, *ego-deficiency* symptoms develop, such as loss of reality testing (delusions and hallucinations), loss of control over unconscious impulses, deterioration of motor coordination and so forth.

Ego therapy means the strengthening and reestablishment of the defeated ego. Thus, the therapist must never become part of the irrational transactions of the psychotic mind, be it delusions, hallucinations or anything else. He must never offer support to erroneous perceptions of reality. The therapist must not interpret unconscious motivation processes if this interpretation may weaken the patient's ego.

For example, the aggressive and obstinate Mrs. Hart was not treated (as she was at home) as the crazy Betsy but as Mrs. Hart who happened to be presently disturbed and therefore hospitalized. The psychotherapist, the nurses and the attendants must not make her regress further and perceive herself as the nasty little Betsy, the "black sheep" as she was in her childhood. Presently, Mrs. Hart is Mrs. Hart; she is a mental patient, but an *adult* patient, and enhancement of her self-esteem is a necessary part of treatment.

Physical appearance and bodily cleanliness are important factors in one's self-image. Uncombed hair, untidy clothing, unshaved face and dirty hands foster the patient's feeling that he is what he deserves to be. Scratching of one's own face or banging one's own head against the wall are clear

indications of an inadequate self-cathexis and lack of self-esteem. Vectorial attitude of the therapist will increase self-love of the patient and will reduce self-depreciation. For love and respect from without enhance love and respect from within.

Vectorial attitude implies our unconditional willingness to help. Schizophrenics learned that parental love was given to them on a Shylock rate of interest. Whenever the mother did a favor to the child, she expected ten times as many favors in return. Whenever she showed affection, she expected in return unlimited gratitude.

Schizophrenic patients tend to test the therapist. Will the therapist demand unlimited obedience, unswerving loyalty and never-ending gratitude? Will he react with disappointment, anger and punitiveness when the patient will not comply and obey, as the patient's mother reacted?

The therapist must never play a parental role. He does neither love nor hate, neither show affection nor anger. His job is to help, irrespective of whether the patient is friendly or hostile. The therapist must never get entangled in the web of the patient's emotions and must retain his unconditionally helping attitude. A responsible surgeon or a dentist does not get angry at a patient who fights treatment; a psychotherapist is expected to be even more rational, balanced and calm.

The patient must be treated in a respectful and dignified manner, notwithstanding his regressive behavior. When an adult patient uses baby-talk, the therapist must never join him in regression; when an adult patient throws a temper tantrum, the therapist must avoid the pitfalls of talking to the patient as if he were a child. Even the most disturbed schizophrenic knows what he is, and the therapist's friendly attitude combined with respect helps the patient to regain self-confidence. Many cured patients recalled that my treating them as if they were normal adults made them feel that they were not completely crazy and there was a hope for improvement.

Control of instinctual impulses is one of the most severe issues in schizophrenia; a catatonic patient in remission describes this inner struggle: "I want to be strong to be able to control myself and here I am again doing terrible things." A gifted latent schizophrenic woman said once: "I can't do what I want to do. I feel like expressing my feelings with quick motions of the brush over the canvas, but something holds me back and I paint silly little houses that I detest. I would like to let myself go in nonobjective art, but something tells me it must be a composition, a plan. Maybe I am afraid to let myself go, for I may do something wrong. So I sit for hours, as if paralyzed, afraid to move. . .

Inability to make decisions and restraint of motor freedom are typical for the schizophrenic type. This conflict between the desire to "let go" and the

fear of one's own impulses may, in some cases, lead to catatonic mutism and stupor. One could not, therefore, encourage the young painter to follow her need for a free expression that would have inevitably led to a panic state and perhaps even to a catatonic episode. Nor would it be wise to enhance self-restraint that would produce an unbearable tension. Thus, the best method was to foster self-esteem; with the increasing self-confidence, the painter was less afraid to express her feelings on the canvas. She began to believe in herself, despite her past experiences.

3. *"One step up"* is the third rule. It implies support of less dangerous symptoms against more dangerous ones, never forgetting that the ultimate goal is to strengthen the patient's ego. When the patient seems to be giving up life, even simple pleasures should be used as a lure.

Pleasure encourages, pain discourages. Especially in the case of the simple-deterioration syndrome, when the patients are profoundly discouraged and suicidal, every bit of joy counts. Thus, the therapist must seek out areas of work or entertainment in which the patient may partake without risking further damage to his catastrophically low self-esteem. Artistic activities—clay work, drawing, playing an instrument, easy handicraft—in short, whatever the patient can do and derive some satisfaction from should be encouraged.

Schizophrenia is a regression for survival. The psychotherapeutic vectorial interaction makes it unnecessary to lose the mind in order to survive. It calls the patient back to life, to growth, to joy, to normal self-protection and self-esteem.

Treatment of an adult schizophrenic as if he were an infant does not serve this purpose; it may foster unnecessary regression. Therefore, I see no reason in giving milk bottles to adult schizophrenics.

4. *The fourth rule is pragmatic flexibility of interaction.* Should the therapist be protective or demanding? Should he interpret unconscious or avoid interpretation? Should he be directive or nondirective, permissive or non-permissive, frank or diplomatic?

Each of these points of view finds supporters and critics. The correct reply is determined by the state of the patient's mind and the ability of the therapist to handle it. When the failing ego is unable to control outbursts of unconscious impulses, the patient's moralistic superego must be supported instead. In hebephrenia, the ego has lost the battle to the id; thus, it may be advisable to strengthen the superego in order to prevent further deterioration. The therapist may, therefore, take a stern and demanding attitude and support whatever moral or religious convictions the patient may have. When the failing ego cannot control incestuous, homosexual or

destructive impulses, the therapist might decide that he must, so to speak, “take over” and check the flood. This decision varies from case to case. In some cases, when the lesser risk is to give direct guidance, such guidance must be given, even if it violates all principles of classic psychoanalytic theory. It is, however, a temporary device, for the supremacy of the ego and not of the superego is the therapeutic objective.

In some severely deteriorated and suicidal cases, the therapist may even side with the id. When in simple deterioration, a patient renounces all enjoyment, pleasure and desire to live, the therapist may become very permissive and encourage pleasure-producing activities. However, any behavior that impairs the patient’s reality testing, control of emotions and control of motility and reduces his self-esteem must be prevented at any cost, for it is ego-damaging.

5. The fifth rule is *individualization*. I have supervised psychotherapists for many years. Quite often a young therapist would ask me: “And what would *you* have done in this case?” My answer is always the same:

Psychotherapy is interaction and depends upon the two interacting individuals. There are rules, but each therapist applies them differently depending upon who is the *therapist* and who is the *patient*. Your job is to understand *your* patient. He is not the same, even if he seems to be, as any of the “cases” described by the masters. In fact, he is not a “case” at all. He is a definite individual, an unhappy and disturbed human being. Try to understand him and at the same time try to understand yourself. Your patient is a withdrawn, or an irritable, or an hallucinating, or a hostile

individual. Can you take that? Can you face that much of an emotional demand? Please don't try to be what you are not. You cannot treat him the way Sullivan, or Fromm-Reichmann, or Schwing or Rosen did. But if you understand *your* patient, and are aware of *your* limitations and resources, and are genuinely interested in the patient, the chances are that you will be a successful psychotherapist.

6. The sixth rule is *reality testing*. The problem of interpretation and insight cannot be answered by a flat “yes” or “no.”

For example, a 30-year-old paranoid patient told me once that his beloved girl who lived 1,000 miles away disguised herself and came to a restaurant as a waitress. He blamed himself for not chasing her; he felt she must be angry at him for he had deserted her. But in the evening she returned to the restaurant; this time her hair was dyed so he could not recognize her. The patient wanted to approach her, but she disappeared.

The patient said he expected the therapist to “side with him” or he would be “through” with treatment. It was obvious that disagreement would have been perceived by the patient as rejection and would have caused further deterioration and possibly an outburst of violence. Yet an acceptance of the patient's delusions could have served no therapeutic purpose.

I started to *test reality* with the help of the patient. I asked him about his girlfriend. He told me she had married two years ago and lived in the South, about 1,000 miles away from New York. His sister wrote him that the young lady had recently had a baby. Gradually the patient himself began to doubt whether the two waitresses were one person. The patient himself remarked, “How could she work in a restaurant if she has a baby? But it was a striking similarity, wasn't it, doc?” At this point, I felt that there was a good opportunity to strengthen his reality testing. I admitted that some people strikingly resemble others and all of us may err. My comment was welcome and the patient smiled with obvious relief. He said, “So, after all, I am not completely crazy. This girl looked exactly like my girl-friend. It was just a little mistake.”

In the past the patient has had visual and auditory hallucinations. He was often ridiculed, ostracized, and insulted. His parents have never missed the opportunity to call him crazy or lunatic.

An overt disapproval of delusions and hallucinations, and even efforts to undermine them by rational reasoning was doomed to failure. A too early interpretation might have caused, in this case, deeper regression and withdrawal.

When one hospitalized patient told me how she discovered God and spoke to him, I did not comment; my attentive listening to her was apparently very reassuring. I began to talk to her about her daily life and chores and she replied in a realistic way. Instead of challenging her hallucinatory omnipotence, I brought her closer to reality. When we talked about occupational therapy, her real achievements in work pushed aside the hallucinatory daydreams of omnipotence.

Even the most disturbed patient is, at least partially, aware of what is going on. He knows who is the patient and who is the therapist; he knows when the therapeutic session comes to an end and when he leaves your office to go back to the ward.

It is not advisable to deny flatly or to contradict the content of delusions and hallucinations, but it is never advisable to join the patient and to share or support the delusions. The therapist may not interpret the content of delusions and hallucinations until he is reasonably sure that the interpretation will help the patient restore his reality testing.

A realistic attitude on the part of the therapist helps the patient to keep contact with reality. One patient insisted on his “right” to call my home

whenever he pleased, at any time of day and night, whenever he felt upset. I told him that if he would do that, I would discontinue my work with him. He accused me of being selfish and inconsiderate. I calmly replied that I needed rest and sleep, otherwise I would not be able to help anyone. If someone asks more than I can do, I must refuse.

7. The seventh rule is *parsimony of interpretation*. Fromm-Reichmann believed that “unqualified thriftiness in content interpretation is indicated even more than with other patients, because, unlike neurotic, he is many times aware himself of the content meaning of his communications.”

The question is not whether to interpret but *when, how and how much*. I give priority to certain types of unconscious material—namely, to those that threaten to disrupt the functioning of the ego. A profound guilt feeling is often the most urgent issue and must be interpreted. If such an interpretation alleviates guilt feelings and reduces suicidal tendencies, it is a sound therapeutic step.

Some cases must go on without any interpretation whatsoever or with only as much interpretation as is given by the patient himself. The main goal of psychotherapy with schizophrenics is redistribution of cathexes and restoration of ego controls; therapeutic interpretation, no matter how correct and penetrating it is, does not mean much unless it helps to redistribute the

mental energies and strengthen the ego.

I have, as a rule, avoided interpretations unless firmly convinced of their therapeutic usefulness at a given moment. In some cases, the last phase of psychotherapy was conducted on more or less psychoanalytic lines, bringing deep insights through interpretation of unconscious phenomena. In most cases, interpretations were given by the patients themselves.

8. The eighth rule is *realistic management of transference*. In his deep transference, the schizophrenic expects love, forgiveness and care from the therapist. Many schizophrenic patients wish to be fed, dressed, supported and taken care of by the therapist who represents the dream-parent. Some patients develop an infantile, symbiotic attachment and call the therapist at any time of day or night, just as a baby would call his mother. Most patients develop powerful heterosexual or homosexual desires reflecting the incestuous involvement with parents and try to enact them here and now. To accept the patient on his terms means to share his psychosis, but to reject him may cause further aggravation and regression.

Schizophrenics are exceedingly sensitive and empathic. A self-centered, aloof, disinterested and emotionally cold therapist could not establish rapport with the patient and, as a result, would not be able to help him. The patient must feel that the therapist is genuinely and profoundly interested in helping

him.

At the same time, the emotionally starved schizophrenic may provoke such a trying situation that unless the therapist is genuinely interested in the patient's case and is ready to go out of his way to help him, the therapeutic relationship may become unbearable to the therapist. *The vectorial attitude of the therapist who is involved with the sufferings of the patient and not with the patient per se*, enables him to be interested in the patient because the patient needs help and not because the treated individual is young and good looking or intelligent.

The maintaining of this *vectorial professional attitude* is a *conditio sine qua non* for a successful treatment. The eventual emotional maturity of the patient will make future protection and guidance superfluous. Psychotherapy is an interaction that aims at being terminated. Once a satisfactory level of cure is attained, the doctor-patient relationship must be dissolved.

There is no one way of how transference should be handled. In most cases, a truthful, honest and simple explanation of the transient nature of the therapist-patient relationship is the best method. When a male therapist quietly turned down the love advances of his female patient, he pointed to his professional duties. The patient took the explanation calmly; it was not meant as a rejection of her as a female nor as a person. She understood the *reality* of

the therapeutic relationship and accepted it. Although she felt frustrated, she understood that this was the right (superego) and realistic (ego) thing to do. The frank and open manner in which transference was handled helped a great deal in psychotherapeutic interaction.

The therapist may at times not tell the entire truth to an agitated patient, but he must never forget it. Nor should the therapist ever lie or make false promises. He must use judgment in timing of explanations. The therapist must not be carried away by anger, annoyance or impatience in the face of the patient's exaggerated demands, but he must treat them in a realistic and professional manner, respecting not only the present feelings of the patient but also his future reactions. A friendly but firm, considerate but realistic, frank but tactful attitude is usually the best way of handling transference. When a patient keeps calling the therapist asking to see him more and more, neither impatience nor yielding to the patient's whims is the proper therapeutic reaction. Impatience is an unfair reaction to somebody's pain but yielding to irrationality encourages irrationality.

A thorough cure is impossible without a resolution of the Oedipal entanglements, but this must be postponed until the patient's ego has gained adequate strength. In some cases, this ideal solution may be unattainable and it may not be advisable to analyze the incestuous impulses but rather repress them. In many cases, it may not be advisable to analyze transference at all.

The strength of the patient's ego is the chief determinant as to how far one may go in interpretation. Not all schizophrenics are schizophrenic all the time and in the same degree. In treating schizophrenics, one must have an estimate of how much their ego is in control of their thought processes. The appearance of primary processes, such as condensation, symbolization, etcetera, should counter-indicate interpretation and especially the interpretation of the transference.

9. The ninth rule requires a firm *control of countertransference*. "What should I do," asked a young psychotherapist whom I supervised, "when L. R. (a beautiful schizophrenic patient) throws her arms around me telling how much she loves me? She is exceedingly attractive and I become sexually aroused. Should I quit psychotherapy as Joseph Breuer did? Or should I 'give love,' hug her, kiss her, comfort her? Would this be unfair, unethical and professionally wrong? Wouldn't it be more harming for the patient to feel rejected? Frankly, I am attracted to her. She is attractive."

There can be no hesitation in such a case. The patient came to receive help, psychotherapeutic treatment. Her desire to go to bed with someone who was kind to her was just one of the symptoms. It was an attempt to prove that she was at least sexually accepted, while she could not believe she was accepted in any other way. To do so is just as unethical as to receive monetary gifts from a patient. In both cases, accepting the patient's offer would be

taking advantage of the state of the patient. She tries to give sex or money because she doubts her own value as a human being. It is a bribe that must be turned down and explained when the patient is ready to accept the explanation.

Any transgression of the vectorial attitude on the part of the therapist is a violation of professional ethics. The therapist must like the patient but this libido cathexis must be vectorial and aim-inhibited. The therapist's love for the patient must be desexualized and never ask anything in return except the agreed upon fee.

Any intimacy between the doctor and patient is a severe violation of professional ethics and of the psychotherapeutic interaction. It may confuse the patient and bring back memories of incestuous parents who, instead of caring for the child, demanded the child's love.

10. Rational handling of hostility. A patient's acting-out hostile impulses may be catastrophic to his environment, as well as damaging to his weak ego. Thus, violence must be banned, repressed and kept under iron control. When patients describe their fights, I do not condemn them, for this would increase their guilt feeling and weaken their ego. But permissiveness on my part would be even more harmful. Whenever the superego has lost control, permissiveness would mean an invitation to license, freedom to the id and

further deterioration of the ego.

Thus, I try to explain that even when they are right, violence is not the right behavior. My comments sometimes bypass the report of the fight as an insignificant event. Once a 25-year-old girl reported that she threw a bottle at her mother, but she did not intend to hit her mother and intentionally missed. I felt that the best policy was not to comment, thus expressing a silent approval for whatever self-restraint the patient has exercised. A male patient reported that he hit his sister; since he might have repeated it, I told him that I did not approve and would not allow any use of force even when he was provoked. I told him that I understood his feelings; obviously he was provoked and momentarily carried away, but I absolutely forbade any violence whatsoever.

Do patients listen? If a good relationship has been established and the therapist is respectful toward the patient, patients accept the therapist as a sort of externalized superego and conform.

Once a hospitalized schizophrenic told me he had hit a nurse: he waited for my reaction. I felt that a lenient attitude would be perceived as siding with the unrestricted id and, implicitly, an approval of insanity. On the other hand, my condemnation of violence would have increased his already unbearable guilt feeling. I therefore made no comment and kept silent for a minute or two. I believe the patient understood my silence and felt grateful. He spoke aloud as if talking to himself: "You don't like it, do you? But you don't say I am a pig. You don't want to hurt my feelings. I guess I am a pig. I am ashamed of myself. I was just carried away. I am sorry. Don't

be mad at me, doc. I shall not do it again. It was silly.”

Schizophrenic patients often display hostile feelings toward the therapist. Sometimes it is a part of their emotional growth.

A 25-year-old schizophrenic explained it as follows: “Doc, I knew I had to fight against you. My mother forced me to be what she wanted me to be. I had to rebel against her to become myself.

I had to assert myself to be me. I had to say what I wanted to say-so she blamed me for her misery.

My father was even worse. Any time I was in trouble, he was making himself sick to avoid responsibility. When I was very sick, he pretended to be sick, too, so he wouldn’t have to help me. Or he would just run away.

I had to fight against you. I love you so much and I did not want to hurt your feelings, but I had to crush your shell. I had to test you and see how much you could take. Would my hostility make you weak and sick? Would you quit me, reject me? My father got sick. My father quit. I had to see your reaction. I had to test you.”

A friendly and understanding attitude on part of the therapist helped the patient to pass the stormy period. The patient was, for a while, highly critical of whatever the therapist did or said. When the therapist remarked, “You are just testing me,” the patient reacted in the above-quoted explanation.

A 40-year-old ambulatory female patient screamed and yelled for fifteen minutes threatening to kill me. I offered her a cigarette and asked about her job. She calmed down and said, “Of course, I yell because my boss yelled at me today. I thought you would yell back, and I would be justified to feel that everybody hates me. But you are calm, friendly, smiling, as if nothing happened. To hell with you! I provoked my boss, but I could not provoke you.”

Fear or hate in face of a threatening schizophrenic may increase the danger of a physical assault. A fearful therapist leads the patient to think that even the therapist believes that the patient is a hostile and dangerous individual. The best way is to preserve the friendly and understanding attitude of the therapist in face of the patient's irrational anger. The calm, self-assured and friendly attitude of the therapist disarms the patient and brings him back to reality.

Sometimes the choice is to *strengthen the patient's superego*. When the therapist, supporting the superego, sternly says, "It is not right," he helps the patient to control hostile impulses. The therapist may say, "I know you would not hurt anyone." Most often it is advisable to continue the friendly conversation and ignore the patient's threats. The therapist must imply or say it directly that he believes the patient is a good and friendly individual, capable of controlling the momentary outbursts of destrudo. At a later stage, when the patient has calmed down, the best policy is to treat the incident as an insignificant loss of self-control that need never occur again. Reproaches will hurt the patient's self-esteem. Should past hostility be recalled by the patient, the therapist must state clearly his disapproval of hostile actions and violence.

In case of physical violence, the therapist must be well protected and absolutely sure that the patient's violence be immediately restrained.

Masochists and self-styled martyrs do not make good therapists. Too often the schizophrenic is forced to feel sorry for the “poor” daddy and mommy. Those who want to help the schizophrenic must be perceived as strong and friendly and capable of a truly vectorial, therapeutic attitude. Hostility and depression are interlocked, for the more hostility is expressed, the more guilt is felt.

To analyze acute hostility is tantamount to inviting an unnecessary challenge. The patient’s hatred towards the therapist is irrational and a discussion of this hostility at this very moment means participation in irrationality. It is almost a *folie a deux* when the patient says that the therapist has stolen his ideas and the therapist desperately tries to deny it or when the patient says, “You hate me” and the irritated therapist repeats, “I do not.”

One should draw a line between physical violence, verbal abuse (“you are a liar”) and expression of hostility (“I hate my brother, but I wouldn’t tell him”). Physical violence must be unconditionally restrained, but verbal abuse indicates that at least some delay and symbolization took place. Hostility is not always transference; when the therapist broke an appointment, the patient’s anger, though exaggerated, is a legitimate expression of defensive hostility. Whether verbal hostility is a realistic or a transference phenomenon, whatever was rational in it should be accepted and explained. Schizophrenics tend to be self-righteous; thus the expression of hostile feelings should be

encouraged, analyzed and worked through.

GROUP PSYCHOTHERAPY WITH SCHIZOPHRENICS

Ten years ago, I began to experiment in private practice with admitting schizophrenics to psychotherapeutic groups with other types of patients. However, I insisted on combined individual and group treatment. There were times when the patient could not open up to the group; there were moments when he needed privacy to confide; and ultimately, every schizophrenic needed a close person-to-person relationship with his therapist.

But, if this is so, why have groups?

One of the main reasons for groups is precisely the vehement transference schizophrenics develop. Freud erroneously assumed that schizophrenia is a narcissistic disorder. Federn and Sullivan, who worked with schizophrenics face to face, witnessed the intense transference phenomena. A schizophrenic easily goes from one extreme to another: from a cold, shallow lack of affect to stormy feelings, from rigid sexual abstention to compulsive promiscuity and from fear of expressing disappointment to malicious destructiveness.

There is nothing more healing for an unrealistic emotionality than a group setting where people are frank and express their feelings in an

uninhibited way. For instance, Rose, a charming, 27-year-old woman believed that I was the greatest thing that ever walked on earth and boldly said, "I want you." She had incestuous experiences with her psychopathic daddy. I faced her offer head on. "O. K.," I said to her, "That would be fine, but from now on who will pay whom, and how much? Is this going to be a pure physical relationship or perhaps a more refined affair, or maybe a marriage? And who will be your therapist from now on while we develop such a nice love relationship?"

The group was waiting for her reaction. She was usually very outspoken and vociferous. My frankness took her aback. She did not want to lose me as her doctor, she said meekly. But she was very much in love with me and several group members expressed words of understanding for her feelings. One by one they came out with confessions. A female group member, 32-year-old, married, admitted that she too had a crush on the therapist. Fred, the homosexual college professor, stammered out his homosexual fantasies revolving around the therapist.

Participation in a psychotherapeutic group and awareness that most patients develop similar infatuations had a refreshingly therapeutic effect on patients. There is nothing more healing than reality, especially in regard to schizophrenics who regress into infantile and often preverbal levels of experience to escape the too painful reality.

The psychotherapeutic group mollifies transference in many other ways. It helps the schizophrenic to see the therapist outside the intense one-to-one human relationship and enables him to assess him in interacting with other individuals. The therapist certainly serves as a parental figure, but not as the seductive, exploitative father nor as the suffering and self-sacrificing mother. The therapist is rational all of the time, come what may. He is friendly and has the patient's well-being on his mind, thus he is truly vectorial as a parent should be. He does not become a partner of the homosexual group member, Fred, nor is he angry at Fred's sexual aberrations. He does not fall apart when the manic-depressive Tom raises his voice (and the chair), nor does he seek revenge.

The incident with Tom is an interesting case in point. Tom was gloomy and irritable, as usual. When he interrupted Jerry, the shy and withdrawn schizophrenic, two other group members protested. Tom yelled, "You bunch of neurotics, what do you know! Doc, tell them to shut up!"

I advised Tom to shut up and wait for his turn. Tom, red in the face, raised the chair threatening me. Jerry was shocked. I turned calmly to Tom saying, "Let that thing stand on the floor." Jerry burst out in tears. He was afraid that Tom would hurt me. Fights are a daily occurrence in the schizogenic family, and all schizophrenics, even those who practice violence, are horrified by violence including their own. My calm was reassuring to Jerry

and other latent and manifest schizophrenics in the group.

Rationality is no less contagious than irrationality, and the multiple irrational transferences can be dealt with better in a group setting than in individual sessions. Seeing one's own irrational behavior projected against the irrationality of others is a much more powerful medicine than just talking about it. A patient often feels better after seeing how silly other people could be. The interaction in groups contains both the regressive elements of transference, and the here-and-now relationship; but the prevalence of the last one opens the road toward rationality.

NEGATIVE TRANSFERENCE AND AGGRESSION

The group setting offers opportunities for checking and analyzing away the negative transferences and hostile acting out. Often it requires a good deal of tact on the part of the therapist to soften the blows and protect those who are so hurt that they cannot take additional offense.

Latent schizophrenics are usually afraid to express their hostility and may bend over backwards to please the most arrogant and aggressive members of the group. For reasons that I shall explain later, I always put two or three manic-depressive patients in with schizophrenics and at least one colorful and nasty psychopathic patient. At the beginning, latent schizophrenics are shocked and terribly scared of the hostility freely

expressed by the manic-depressive patients (I include them in the category of dysmutuals who swing from love to hate, from elation to depression) and even more so by the psychopaths (I call them hyper-instrumentals, pointing to their unlimited selfishness).

As a rule, hostility is directed against the therapist. Latent schizophrenics re-experience severe fears; they are afraid that the therapist will either lash out back at them or fall apart as their parents did. However when the therapist reacts calmly to hostility, analyzing its sources and explaining its components, the hostile assaults end, as a rule, by disarming the assailants. This offers an unusually valuable therapeutic experience. Latent schizophrenics learn to accept hostility as a normal human reaction, whether it originates from themselves or is expressed by other group members.

Paranoid schizophrenics may express their accusations verbally. Those who act out physically must not be admitted to a psychotherapeutic group. While the expression of hostility should be encouraged, the underlying rationality or irrationality must be scrutinized.

One patient maintains that the therapist calls him frequently at his home, saying nothing and hanging up on him. Another patient resents the therapist's refusal to give her additional sessions, while she believes that he gives them willingly to all the other patients. In both cases, similar complaints

by the other group members and their criticism by the group have a healing effect. These patients themselves begin to question the accuracy of their stories, notice the displacement of their aggression and become more amenable to admitting their true grievances.

Another patient was constantly critical of others while blaming them for being unfriendly. She was domineering, bossy and provoked fights. The group acted in her case as sort of an ego, helping her in checking reality and becoming aware of her anxious belligerence.

I do not admit hebephrenics to my groups, because hebephrenic behavior may be too disruptive for the functioning of the group. I do occasionally admit catatonics in remission. When they sometimes report their past hostile acts, the group usually takes a tolerant attitude that alleviates their guilt feelings.

The simple deteriorated schizophrenics usually benefit by group interaction. Being withdrawn, shy and suffering from a severe feeling of inferiority, they usually require some time to get adjusted to the group.

The interactional process in the group is a two level process. George, thirty-three, was afraid of everyone on his job and in his neighborhood, but terrorized his frightened parents. He was exceedingly friendly and nice to strangers and selfish and exploitative to his own family. He acted out this

tendency in the group; he was afraid of and tried to please the other group members but was arrogant in regard to the therapist, whom he expected to be permissive no matter how he behaved.

I was not permissive. I strongly disapprove of giving baby bottles to adult schizophrenics and making them regress. Schizophrenia is a regressing process to begin with and whoever intends to help a schizophrenic must help him to grow *up* and not to grow down. I did not interpret George's transference; interpretations, while usually useful, would have been meaningless in this case. I was George's third therapist, and he knew by heart all the stories about Oedipus the King. What George needed and received at this point was firm interaction with someone who would not take any nonsense. The interpretation came from the group members who noticed how nice he was to the loud Laura and how rude to the therapist.

Once a patient pulled a knife on me. Needless to say, I had no time for interpretation. I had to use the same techniques as with George—namely, to take over his superego. I gave firm orders and the knife landed safely on my desk.

INTERPRETATION AND INSIGHT

Hegel's famous dictum "Minerva's owl arrives at sunset" applies to the treatment of schizophrenics. The owl of insight should come toward the end

of treatment, and in some cases, its presence is altogether superfluous. One can talk himself blue to schizophrenics without doing them one bit of good. For example, one brilliant latent schizophrenic young woman led a senselessly promiscuous life, often getting herself pregnant. She knew that she was self-destructive; she read Sullivan, Menninger and Fromm. But as soon as the transference was deep enough, she gave up promiscuity.

As mentioned before, interaction is a split-level process. It goes on in the realistic field of the here-and-now relationship, but also in the unrealistic field of transference buried in the unconscious memories of infantile experiences. A mere unraveling of the past does not produce a cure. In fact, most schizophrenics have an uncanny access to the unconscious, and they are the first ones in the correct interpretation of dreams brought by other group members. They are often morbidly aware of their unconscious impulses.

The interpretation of unconscious processes in latent schizophrenics should be avoided or at least postponed until the patient's ego is strong enough. A premature interpretation may destroy the defenses and precipitate a psychotic collapse. Interpretation of unconscious material must be highly individualized.

This caution does not apply to the here-and-now realistic interactional processes. The rule of interpretation in schizophrenia reads: Start from the

surface and proceed cautiously. Go as deeply as necessary but avoid tampering with a weak ego structure. But do not be afraid to tell the truth concerning overt behavior, for truthful and realistic statements strengthen the ego. Sometimes I wonder whether there is any other place outside of the psychotherapeutic groups where truth is not only preached but practiced. In real life, full of vested, invested and hidden interests, people rarely tell each other the truth. I do not favor alternate group sessions, nor do I allow socialization outside group sessions. Thus, in a group session, love does not lead to a marital union and hate does not lead to destruction and murder. People tell each other the entire truth, because the fear of consequences which paralyzes people in an open society is removed in the group setting.

Tom told the unfaithful Marianne, "You are whoring away your marriage." Marianne cried and asked for my protection. I commented, "It is important for you to know that some people view your behavior in this way."

REMARKS ON GROUP STRUCTURE

I would never treat a group composed of schizophrenics only. Maybe it is because I am not strong or brave enough to do so, but I believe there are also objective reasons to consider.

I believe all mental disorders can be divided into five *levels of severity* of the disorder (neurosis, character neurosis, latent psychosis, psychosis and

dementive stage) and three *types* representing the main trends of the overt behavior.

CLASSIFICATION OF SOCIOGENIC MENTAL DISORDERS

	<i>Hyper-instrumental Type (I)</i>	<i>Dysmutual Type (M)</i>	<i>Hyper-vectorial Type (V)</i>
<i>Neurotic Level</i>	Hyper-instrumental Neurosis (Certain anxiety and depressive neuroses)	Dysmutual Neurosis (Dissociative and conversion neuroses)	Hyper-vectorial Neurosis (Obsessional, phobic and neurasthenic neuroses)
<i>Character Neurotic Level</i>	Hyper-instrumental Character Neurosis (Sociopathic or psychopathic character)	Dysmutual Character Neurosis (Cyclothymic and hysteric character)	Hyper-vectorial Character Neurosis (Schizoid and compulsive character)>
<i>Latent Psychotic Level</i>	Latent Hyper-instrumental Psychosis (Psychopathic reactions bordering on psychosis)	Latent Dysmutual Psychosis (Borderline manic-depressive psychosis)	Latent Vectoriasis Praecox (Borderline and latent schizophrenia)
<i>Manifest Psychotic Level</i>	Hyper-instrumental Psychosis (Psychotic psychopathy and moral insanity)	Dysmutual Psychosis (Manifest manic-depressive psychosis)	Vectoriasis Praecox (Manifest schizophrenia)
<i>Dementive Level</i>	Collapse of Personality Structure		

Obsessive compulsive, schizoid and schizophrenic patients are included in the hyper-vectorial type. As explained before, these people are forced in their childhood to make costly object cathexes of their libido which inevitably

lead to an impoverishment of self-cathexes. The hyper-vectorial patients fear their own hostility and over-repress it. In the overt psychotic stage, destrudo breaks through, causing their overgrown superego to increase its self-destructive assaults.

The hysteric and manic-depressive patients swing from one extreme to the other—from love to hate, from self-directed to object-directed love or hate. In this dysmutual type, the superego is inconsistent, shifting from merciless self-hate and depression to an euphoric self-love of elation.

I believe a group is balanced *horizontally* when it comprises all three types of mental disorder, and it is balanced *vertically* when it is not spread too much in the levels of severity. The horizontal balance permits a good deal of therapeutic interaction, for each of the three clinical types offers an emotional challenge to the other two. The vertical balance facilitates intragroup communication; for instance, a neurotic can understand a character neurotic (one level before) and perhaps a latent psychotic, but could not communicate too well with a too severe case.

REMARKS ON THE THERAPIST

I am in favor of a flexible approach bordering on inconsistency. With some patients, one must be supportive, with some not. I suggest certain basic rules related mainly to the three clinical types with variations necessitated by

the level of regression. But even this is not enough. One has to allow a large margin for the personality of the therapist. I could not act the way Schwing, Fromm-Reichmann, Federn, Sullivan or Rosen acted. There are general principles, but each therapist applies them differently in a way appropriate to his own potentialities and to the needs of a particular patient.

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