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THE ORGANISMIC APPROACH

KURT GOLDSTEIN

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Organismic psychotherapy may seem a paradoxical term. For the organismic approach in general—from which we here consider the problem of psychotherapy —the concept is basic that there are no separate apparatus or mechanisms determining the activity of a living being. The organism is considered a unit, and all behavior—normal and pathological—is an expression of the different ways in which the organism functions in its totality. The organization of this unit depends on the task with which the organism is confronted and with which it must come to terms. How this is achieved is certainly based on the organism's structure, but ultimately it is determined by the basic trend of organismic life. Any behavior, normal or pathological, can be understood only if we consider it as an expression of the trend of the organism to realize all its capacities in harmony, in other words, its nature. The degree to which this realization is fulfilled is dependent upon the relationship between the organism's capacities and the demands of the outer and inner world, that is, on how much the organism can come to terms with them (p. 197).

What appears to be the effect of the function of a part of the organism corresponds— considered from the organismic approach—to the activity of this unit in a definite organization, by which the organism comes to terms, as

best he can, with the demands. In this organization, the process in one part is in the foreground and represents the figure of the figure-ground organization that underlies every performance of the organism (p. 109), whereas the activity in the rest of the organism represents the ground belonging to the definite figure which appears, on face value, as *the* reaction to the demand.

We are interested here in the consequences that the organismic point of view has on psychotherapy. How can one justify a therapy that considers *one* part-process of the organism, the psychological, as all-important as psychotherapy pretends; in other words, how is psychotherapy possible from this point of view? Before trying to answer this question, we must consider at least briefly what the so- called psychophysical relationship, especially the psychological influence on physical phenomena, can mean, restricting our discussion to the problem: Does our approach provide a concept on which psychotherapy can be based?

The Psychophysical Problem

The discussion of the psychophysical problem has been undertaken in the past, particularly by philosophers and psychologists—without, however, many fruitful results. At the beginning of this century, it began to attract the special interest of physicians when it became evident that not only so-called psychological but also some somatic conditions—such as asthma or

hypertonia—could be improved by psychological therapy, and thus it became necessary to decide whether we should apply a psychological or a physical method, or both, in a given case. It was this decision that demanded a search for a better clarification of the psychophysical relationship.

It is natural that the psychotherapists, by their success, were induced to ascribe a primacy to the psychological phenomena. Here, experiences with hypnosis and with the application of Freudian ideas were of special significance. There was a time when the "psychological" was considered so all-important that psychotherapeutic treatment even of bodily diseases was inaugurated, as, for instance, by Groddeck, whose ideas attracted considerable attention after publication of his book, *Das Ich und das Es (The Ego and the It)*. Even if this extreme point of view did not find much acceptance in the therapy of physical diseases, the particular evaluation of the "psychological" is reflected in a number of prescriptions in psychotherapy, especially in psychoanalysis—for example, the strict demand to divert, as much as possible, the attention of the neurotic patient from a somatic interpretation of symptoms, and others which will be discussed later from the organismic point of view. It also had a considerable influence on the practical physician's concept of the role the "psychological" plays in the development of disease and in therapy. Certainly, the somatically minded physician had never denied the significance of the psychological in the development of disease. He was well aware of the relevancy of the mind for what is going on

in the body in disease, and he appraised the implication of psychic phenomena. He never considered them irrelevant epiphenomena, as philosophers and psychologists had often done. Indeed, he attributed to the mental aspect a special domain, separated from the somatic and only secondarily connected with it, corresponding to the general natural-science concept that the organism is constructed out of parts that only secondarily are connected with each other.

The observation of symptoms and the effect of psychological or physical stimulation on each other suggested a mutual relationship of separate processes. But consideration of the phenomena from the organismic point of view reveals that this relationship becomes understandable only if one relates it to the activity of the whole organism—influenced on the one hand by psychological, on the other by physical stimulation, which in the organism are never isolated processes. They are made to appear thus only by the use of isolating abstract consideration. Therefore, when we speak of psychological or physiological phenomena, we should be clear from the outset that these words represent only imperfect descriptions of the facts, that they refer only to the "figures" in the present process of the whole organism. They represent data which can be evaluated in their significance for the behavior of the individual only when we consider them in their functional belongingness to the present organization and activity of the whole individual organism.

From this point of view, it follows that psychological and physiological processes are determined by the same laws. This is not because the laws are equal in two different fields; rather, they are the laws of the function of the organism as a whole, which appear in the same way in the two groups of phenomena. In other words, we are not justified in speaking of parallel processes—neither of isomorphism in the sense of Koehler.

In this conceptual framework, understanding a mental or physical condition that we call sickness means (1) determining the significance of the psychic or physical processes in the development of the condition; (2) determining the role that psychic or physical phenomena play within the totality of the clinical picture and the experience of the patient; and (3) determining by which means—whether the psychological or the physiological or both —the abnormal condition can be brought back to the "norm," how the patient can best regain his health—that is, become able again to realize his nature to the highest possible degree.

Sickness from the Organismic Point of View

Before one can apply these concepts to the procedure in psychotherapy, one must define the meaning of sickness within the organismic framework. Sickness is not simply any modification of the structure or functioning of the organism, nor is it a loss of definite psychic or somatic performances.

Differently considered from a differently determinable "norm," such a modification may be an anomaly, but the individual with this anomaly may neither appear, nor feel, sick. (Goldstein, 1943 p. 249) The individual becomes sick if the condition brings the organism into a state of disorder—into catastrophe —so that he is no longer able to realize the capacities inherent in his nature—at least, to a degree that life still appears to be worth living.

The objectively verifiable changes of special functions, bodily or psychological, are the expressions of this state of disorder of the organism—of the fact that the normal, adequate relationship between the organism and the demands made upon it, which is the presupposition for the realization of the organism's capacities according to its nature, no longer exists.

The disordered function—the catastrophic condition—is revealed in the disordered behavior—that is, in different symptoms—and is accompanied by the experience of anxiety. The anxiety is generated not by the experiences of failure brought about by the actual damage, psychological or material, of the organism, but by the experience of danger to the realization of that individual's nature which is produced by the failure, (pp. 291 ff.) The danger need not even be real; anxiety occurs also if the individual only imagines that he is no longer able to realize his nature.

Therapy from the Organismic Point of View

From this characterization of "being sick," it is understandable that breakdown can be the effect of very different events, bodily or psychological —in other words, any condition producing such disorder that the realization of the individual nature becomes essentially impossible.

Furthermore, the outstanding symptom need not be directly related to the cause of the disease; the patient, however, assuming that it is, and suffering from it, may demand its elimination, particularly if the symptom consists in unbearable pain or anxiety. Obviously, one might be inclined to respond to this appeal, particularly if alleviation of the symptom might make the patient more responsive to the real therapeutic procedure. Reducing pain or anxiety by medication, shock treatment, and so forth, is justified however *only if one explains to the patient that the elimination of pain does not represent the real treatment* and might conceivably delay the final improvement.

Any attempt to reduce disturbing symptoms—that is, symptomatic therapy—demands careful consideration of the effect this may have on the self-realization of the patient. This consideration requires evaluation of the pre-morbid personality, the character of the patient, his goals for further life, what can be expected from more intensive treatment in respect to greater or lesser restitution of the personality, and what that will mean for his future life. Whether or not this procedure proves to be useful or harmful is

determined largely by the patient's capacity for understanding the physician's intention. This capacity will differ, depending upon the degree of the mental defect caused by the underlying disease.

I want to discuss, for purposes of illustration, a condition in which the defect is very severe—as, for example, the case of brain-damaged individuals.

Because frequent catastrophic conditions produce severe disturbances in brain-injured individuals, it is obviously necessary to change their environment so that it no longer makes demands upon them that they cannot meet. In doing this, we are only imitating in treatment what would normally occur passively; for we observe that this change in milieu seems to develop spontaneously after a certain time, even without treatment. This modification occurs because the patient, by withdrawal from the world around, eliminates a number of stimuli, including those producing catastrophe. The defect remains the same (as special examinations reveal), but the patient is in a more ordered condition and able to perform many undisturbed activities which were not possible for him previously. (For detailed observations of this change of behavior, see Ref. 6, pp. 35 ff.) This change of behavior is the result of an adaptation on the part of an individual, due to the trend of the organism to realize its nature—in a brain-injured individual, to stick to the preserved capacities, that is, the only thing he is able to do. He cannot avoid demands voluntarily. These demands are eliminated by this sticking to what he can do.

In terms of the organismic concept of sickness, we can say that the patient is in a "healthier" state once he has achieved this new balance between damaged function and limited environment—and there is no doubt that he also feels healthier. This state does not represent normalcy, however; it goes along with more or less outspoken restrictions of the individual's capacities, of his nature; a consequent shrinkage of the patient's present world as compared with his world as it existed before. Life may be more secure, but one can assume that, if the individual were aware of the restrictions placed upon it, he would not consider it still worth living.

Because of his mental defect, however, a severely brain-injured individual does not recognize this shrinkage of the world and his personality, especially when he lives in a custodial environment that allows the patient to get as much personal satisfaction as he needs. He may not recognize that this "custody" excludes him, in a high degree, from normal communion with his fellow men. As a matter of fact, should he become aware of his factual position —something that can happen easily if he is approached by someone who does not realize his vulnerability in this respect—this awareness alone hurls him back into catastrophe. The occurrence of such shocks during treatment—when retraining demands that the patient be confronted with tasks he cannot fulfill—is avoided more or less successfully by the transference situation (see later).

Thus, some kind of self-realization is achieved here, in spite of the restrictions imposed by the protective mechanism.

The situation is different, of course, when we deal with patients who are aware of the restriction of their world as a consequence of the protection against distress and pain. For mentally normal persons suffering from severe bodily diseases, or for neurotics and psychotics, living under such restrictions may create either temporary or insurmountable problems. A patient with a severe heart failure, for example, may be able to bear restrictions—such as those imposed by the need for bed rest—not only because he feels that they will mean an improvement in his heart disturbances but also because he is able to realize his needs to a considerable degree in spite of them, and because he hopes the restrictions will be only transient.

On the other hand, the person suffering from a chronic bodily illness may not always be able to bear the restrictions imposed by the procedure necessary to avoid pain. If such a patient were to become convinced that this condition of living was to be permanent, he might reach the conclusion that suicide is the only way out—the only means of protecting himself against the horrifying affliction of not being able to carry on with tasks that are, to him, essential; the only way of escaping the perpetual catastrophes and anxiety and, particularly, the exclusion from his world. Then we meet the apparent paradox (from our point of view, a logical conclusion) that an individual

prefers death to a life so shrunken that it appears to him no longer suitable for realizing his true nature.

The situation becomes particularly complicated in neurotics. Although the patient may, for a certain time, live comfortably with the protective and defense mechanisms developed during the early years of life against conflicts and anxieties, when confronted with new conflicts—particularly the new external and internal demands which arise during puberty—he may begin to feel unbearably restricted because it becomes impossible for him to realize his nature in these circumstances. There is only one way out of the dilemma if he wants to avoid suicide, if he wants to "exist." He has to learn to bear some conflicts, some suffering and anxiety, voluntarily. The choice lies between this and the unbearable restrictions. If the patient is able to make this choice, he may still suffer, but he will no longer feel sick; that is, although he may be somewhat disordered and stricken by anxiety, he is, at least, able to realize his essential capacities to a considerable degree, thus regaining health.

Health, in this framework, is not an objective condition which can be understood by the methods of natural science alone. It is, rather, a state related to a lofty mental attitude by which the individual has to value what is essential for his life. "Health" appears thus as a value; its value consists in the individual's capacity to actualize his nature to a degree that, for him at least, is essential. "Being sick" appears as a loss or diminution of the value of self-

realization, of existence. The central aim of "therapy"—in cases in which full restitution does not occur spontaneously or is not possible at all—appears to be a transformation of the patient's personality in such a way as to enable him to make the right choice; this choice must bring about a new orientation which is adequate enough to his nature to restore the sense that life is worth while.

Generally, it is demanded that psychotherapy avoid value judgments. As far as the therapist's attitude toward the failures of the patient is concerned, this demand is correct. The therapist must not impose his own values upon the patient; but that does not mean that the problem of value has to, or even can, be avoided totally. Freud, for example, believed that therapy should be based on scientific methods and concepts alone. "All that is outside of science is delusion, particularly religion." Whether or not Freud's attitude was free of value judgments is debatable, since a positive belief in natural science alone is in itself based upon a value judgment. Freud's stress on the significance of pleasure as a driving force in man was based on his special estimation of it for normal life, on the value he saw in the relief of tension.

How efficient an individual is in making the aforementioned choice and in enduring conflict and anxiety depends upon various factors.

It depends first, upon the structure of the premorbid personality—

particularly the nature of his "inborn character." Here the intrinsic *courage* of the individual is of paramount importance (cf. Ref. 6, p. 306). Therapy has to make him aware of his character, able to accept the limitations which belong to his nature, to recognize life's value in spite of them, and to see a possibility for self-realization. Therapy may help him to learn that it is possible to meet the conflicts with "fear" rather than overwhelming "anxiety."

Second, the capacity for choice depends upon whether the totality of the personality is involved in pathology or an essential part of it has remained normal. This difference shows up when one compares neurotics with patients suffering from organic brain defects or from schizophrenia. In the latter cases, the use of the abstract capacity, which is prerequisite for exercising choice, is reduced. Under these conditions, the patient can only try out the possible ways of behavior which may best bring about "order" and satisfactory use of his capacities; the brain-injured does it by sticking to what he is able to do in the protective environment; the schizophrenic by withdrawing more or less completely from the world and building up his own world—by using his preserved capacity for abstraction.

Finally, the choice is dependent upon past experiences and their influence on the patient's current condition, particularly with regard to how much they interfere with solving the current conflict.

How can we help the neurotic patient to find the new orientation of his personality which will bring about the condition of health?

Our first task is to help the patient in his search for the causes which have previously produced disorder and anxiety. The conflict with which we are concerned is always a current conflict. There is no doubt, however, that the current conflict also depends upon the aftereffects of previous experiences, physical and psychic alike. Here the protective mechanisms that were developed in childhood to protect the individual against anxiety can have a disastrous aftereffect. Their persistence shows, as we have already mentioned, in some traits of the neurotic's behavior which themselves produce conflicts. Thus, unearthing of previous events and experiences is of paramount significance for psychotherapy. But the material which comes to the fore in the utterances of the patient has to be scrutinized and used with the greatest care. What can be uncovered at present does not at all correspond to the real previous experiences—not even to the fantasies which, although they may have played a great role in childhood, may not be effective in the present conflicts.

Discussion of this important point in detail would involve the consideration of a number of complex problems. I should like, however, at least to point them out. First, there is the problem of the essential difference in the structure between the experiences of the infant and those of the adult.

This makes it difficult for the latter to recall the previous experiences. Recollection presupposes a similarity between the situation of the organism at the time of the experience and its condition when remembrance has to take place. As I have explained on another occasion (cf. Ref. 5, p. 317), the feelings and attitudes which are predominant in childhood usually cannot be re-experienced by the adult because they cannot as a rule be made conscious; they belong to a level of awareness which cannot be authentically exposed in the psychotherapeutic situation willingly (see later).

Second, during the years of development, the aftereffects of childhood experiences undergo systematic modifications produced by the maturation of the personality and by the cultural influences under which the child grows up. Schachtel has provided us with important insights into this complex phenomenon. Furthermore, aftereffects of previous experiences normally become effective (or not effective) only according to their significance (or non-significance) for self-realization in the present.

I doubt whether repression as it was described by Freud plays an essential role in forgetting in childhood. Much of what is called repression is, I believe, the effect of the modification of the child's behavior brought about by the personality changes of maturation and by influences from the outer world. These factors create new patterns which determine the behavior of the organism. Elimination of some previous experiences (called repression)

occurs when the maturing organism readapts itself to a new environment and gains new patterns, of which those that appear to be "repressed" actually are no longer a part. The former reactions have not been repressed; rather, they cannot be remembered because they are no longer part of the attitudes of later life and, therefore, cannot become effective. They can be revived or recalled under definite conditions, conditions similar to those under which they originated, such as, for example, the psychotherapeutic situation, in free associations, and in dreams; but what now comes to the fore as recollection is not an authentic reconstruction of the child's original experience. Overlooking this difference has led to many mistakes of interpretation.

The ambiguity of language creates particular difficulties in the interpretation of the adult's description of "childhood experiences." The same word may have different meanings in different situations; this statement is true, generally, but it is especially true of the way a child uses words. Just as adults and infants experience objects in ways that differ in principle, so also may adults and children use the same words to describe totally different experiences. The patient must use the language of the adult when he refers to previous experience, but this language is particularly unfit to describe the childhood experience because it is—as a rule—built to conform to the demands of the objective adult world. This language, unfortunately, is inadequate to describe the feelings, attitudes, etc., which are predominant in infancy and childhood, even when the feelings are recalled more or less

clearly. Thus, when the patient speaks of father, mother, child, sexuality, and so forth, the therapist must remember that the words may not necessarily convey an accurate impression of what was actually going on in the child.

Finally, the therapist must remember that recollection is often impeded by the anxiety and catastrophes which arise from the patient's growing awareness of the dangerous conflict implicit in some experiences. The patient fights against relinquishing his previously acquired protective mechanisms. Overcoming this resistance is one of the most important functions of psychotherapy, for two reasons: first, only when the resistance has been dissipated can the patient become aware of his conflicts; second, it is particularly through the treatment of resistance that the patient gains insight into the psychic processes underlying his conflicts.

Recalling dangerous experiences is made easier for the patient if he is protected against the anxiety attached to the recollection. This protection is achieved through the development of the transference relationship. Since Freud's earliest formulations, transference has been considered a tool essential in the treatment of neurotics. In my experience, it is equally essential in the treatment and retraining of patients with organic brain lesions. In such cases, the retraining situation itself produces catastrophic conditions so frequently, even in the everyday life of the patient, that all retraining must begin with the development of transference.

The transference problem is significant for all forms of therapy and we therefore have reason to discuss it here from the organismic point of view. I have come to the conclusion that transference is effective in the treatment of all diseases, organic or functional; secondly, it always has the same basic character, which is modified somewhat in the different aspects of sickness. The similarity is understandable inasmuch as we are dealing with the same dynamic problem in all conditions of sickness —the individual's reaction to unbearable conflicts and restrictions. Whether the causes of the conflict lie in an organic or a psychological defect is not relevant to the central issue.

In mentally normal patients with chronic somatic diseases, the helpful aspect of the patient-physician relationship may lie in the patient's confidence in the capacities of the physician, in his reputation as a skilled and honest man. Indeed, only if a deeper mutual relationship has been established—if the patient believes that the physician is as deeply involved as he himself is—will the patient continue treatment in the not uncommon cases w here the therapy does not seem to lead to improvement, or where the symptoms increase. The development of that deeper relationship becomes imperative in the treatment of patients with whom, because of a defect of abstract attitude, a normal understanding is not possible, or is possible only to a restricted degree. With such cases as brain-injured patients, for example, the physician may not even be able to acquire enough information for retraining the patient through the usual examinations, because these for the most part require some

degree of abstraction. The physician will have still more difficulty in evaluating the significance of the defect for the patient's future because, in order to evaluate the patient's potential for improvement and for the eventual achievement of the highest possible degree of self-realization, the physician must determine how much of the pattern which developed after injury as a protective mechanism against catastrophe can be eliminated, how much must not be touched because of the unbearable catastrophe that might ensue. Such an evaluation requires deep insight into the patient's previous personality, his aims, hopes, fears, and conflicts—and ways of handling them—as well as insight into the changes produced by the brain damage. Only through this insight will the physician be able to help an individual who, lacking capacity for abstraction, cannot grasp the meaning of the procedure and is unable to check directly whether the instructions he has to follow will be useful for him, and who further has to learn not to be afraid of making mistakes. This presupposition of all the effects of retraining is still more important when the patient is later expected to use what he has learned without being able to understand whether it is correct or not. The patient will only be able to meet such demands when he is convinced that not only is the physician capable of helping him but he can be trusted absolutely.

Such a conviction cannot be acquired in the usual way of communication, but it can be built up. It originates from communication on that level of consciousness which I have distinguished as level of awareness

(cf. Ref. 4, p. 311) which is preserved in the patient in spite of the defect in abstraction. In this way, direct and immediate relations through common activities, feelings, and attitudes become effective in building up a state of solidarity, a state which I call communion. This state exists also between normal individuals. Without it normal mutual understanding is not possible (cf. Ref. 9). It usually exists beside, and embedded in, the level of so-called consciousness in which abstract attitude plays a predominant role; it normally originates in our voluntary act of giving ourselves over to it. The brain-injured individual is not able to develop such a relationship voluntarily because to do so presupposes abstract attitude. Communion can originate for him only in the milieu, and this must be created by the physician.

But it is not enough that the physician create the environment out of which communion may develop; he must also participate in the communion. This demands a deeply sympathetic attitude toward the patient. The physician must see him as a human being like himself with whom he can live in spite of the fact that the patient is deprived of essential human capacities. Only if he achieves this kind of countertransference will the physician be able to communicate with the patient and behave in such a way that the patient not only feels protected against the occurrence of catastrophes but understands the significance of the physician's procedure for using the psychic capacities still at his disposal for his existence in the future.

Before discussing the problem of transference in neurotics and schizophrenics, I would like to make a general remark concerning the phenomenon. There may be doubt as to whether what we describe as transference in organic patients is identical with the usual concept of transference, and whether we are justified in considering it as only a modification corresponding to the difference of the condition in neurosis and psychosis. In order to answer the question, we must consider the situation in these diseases somewhat in detail.

Our experiences with organic patients have taught us the particularly important fact that a state of transference can develop in an individual with a defect of abstraction. This brought us insight into the difficulties and the possibilities of developing transference in schizophrenics.

Freud thought that the treatment of schizophrenics through psychoanalysis would scarcely be possible because the development of transference in these patients is made difficult, even unlikely, by their narcissism—an observation which holds true if one tries to use the methods he found useful in neuroses.

To explain why the establishment of transference is so difficult in schizophrenia, it would be necessary to give a detailed account of the mental condition in this illness. Opinions on this subject have changed with the times.

Different mental defects—lack of attention, disturbance of apperception, weakness or narrowing of consciousness—have been considered as explanations of the variety of symptoms in schizophrenia. I have tried to understand schizophrenic behavior as a change of personality, approaching it as I did behavior defects in organic brain damage (see Ref. 8, p. 17). To my knowledge, Storch was one of the first to emphasize the change of personality in its totality by stressing the abnormal concreteness of the schizophrenic. But his assumption, to which mine corresponds, met with little approval in later interpretations of schizophrenia. Only after careful investigation of schizophrenic behavior by means of performance tests such as those used for study of impairment of abstraction in organic patients did the problem of total personality change in schizophrenia begin to attract attention (see Ref. 11).

The Russian psychiatrist Vigotski, following the organismic concept of the defect in organic patients and using the procedures of investigation initiated in our studies, demonstrated impairment of abstraction and abnormal concreteness as characteristics of schizophrenia. His findings were confirmed by the studies of Hanfmann and Kasanin, Bolles and myself, and others. Vigotski spoke of disturbance in abstract thinking. We considered the anomaly of thinking as *one* expression of the change of the total personality, an assumption which was agreed to by Hanfmann in so far as she believes that the intellectual and emotional disturbances are probably only two

manifestations of one basic change.

This impairment of abstraction might suggest that schizophrenia is an organic disease. But such an assumption did not seem appropriate. Looking for another explanation of the symptoms, I did a careful study of the phenomena in the concrete behavior of schizophrenics and compared these with the phenomena in the behavior of organic patients. The results were illuminating: the comparison showed essential differences between the two groups.

It is not necessary to enter into a detailed discussion of these differences in order to understand what these findings indicated about the characteristic change of the schizophrenic personality and its significance for the development of transference. It may be sufficient to mention the main differences. The pattern which the organic patient shows in his concrete behavior can be understood as being due more or less to disintegration of sensory, motor, or mental processes. They show the characteristics of the dedifferentiation of function typical of all organic damages. The schizophrenic, on the other hand, develops characteristic individual patterns in his concrete procedure which reveal influences from the patient's ideas, feelings, etc. All this pointed to qualitative differences in the origin of the impairment of abstraction. This origin would be found in consideration of this defect in its relation to the totality of the schizophrenic picture, its

development, its mental features, etc., which cannot be given here. It may be sufficient to point to the disturbance of abstraction in relation to one symptom of schizophrenia which is generally considered outstanding—the withdrawal of the patient from the world—and to consider why the schizophrenic withdraws. Could the impairment of abstraction be considered a means to guarantee this withdrawal? In this respect, again, our experience with brain-injured patients became important, for we have learned that, through their concreteness, a great number of demands made by our world which he cannot fulfill and which send him into a state of anxiety are eliminated. The organization of our normal world shows a greater dependence on the individual's capacity for abstraction than one is usually aware of. Is the concreteness of the schizophrenic a means of avoiding dangers which arise for him out of our world, dangers based on conflicts between him and our world which may lead him to catastrophe and anxiety? There is general agreement that experiences in early infancy play an essential role in the development of schizophrenia. Sullivan stated that the damage to the interpersonal relationship between infant and mother is of great significance for the development of schizophrenia. I consider the situation as one in which the original organic unity between infant and mother is disrupted by birth. Catastrophes, anxiety, and hindered normal development may ensue if the disruption is not repaired. In this stage, the new unity between infant and world must be built up at a psychophysical level. To what

extent this can be achieved depends upon the conditions of the environment, particularly on the behavior of the mother or other significant persons. Not only must the various needs of the infant— corresponding to his developing capacities— be adequately met, but, even more important, the disrupted communion between infant and world (particularly the mother) must be restored. Otherwise catastrophes may occur which the infant is unable to bear.

The infantile organism reacts to catastrophe by escape, for the organism at this stage of development is not able to build up other protective mechanisms. (In this stage, the organism can be compared in this respect to brain- injured patients with severe impairment of abstraction.) The result is that the infant tends to withdraw from the world, particularly the private, personal environment. Persons who later become schizophrenic often show symptoms of this tendency—shyness, suspicion, anxiety, withdrawal—at an early age, before the disease, under the pressure of special conflicts, breaks out.

From this point of view, the abnormal concreteness appears as a secondary phenomenon, a protective mechanism against unbearable danger and anxiety. (In principle, my interpretation of schizophrenic withdrawal agrees with Arieti's concept.) The assumption that the danger arises from the world of personal relations, and that the patient tries to withdraw because of

the anxiety stimulated by it, makes a number of peculiarities in the patient's behavior understandable. In this respect I must mention that, if lack of abstraction is a protective mechanism, the withdrawal will be utilized only, or particularly, in situations which are dangerous for the patient; it will be less evident when there is no danger. We see that the patient does not always manifest the failures arising out of concreteness. In the same way, it is understandable that the child who is potentially schizophrenic may develop normal intellectual capacities. One has the impression that, although the individual develops his intellectual capacities, they too represent a kind of protective mechanism, because intellectualization involves no personal relationship. In other words, since, as Abraham and later Federn have stressed, the schizophrenic does not always show behavior symptoms of withdrawal, we can conclude that the patient is not *impaired* in his abstract attitude as is a brain-injured patient, but that he does not use it in dangerous situations.

Since the patient sees the personal world as dangerous, it becomes understandable that it is difficult, and may even be impossible, to develop transference. The patient wants to avoid any communication; he resists, sometimes violently, if his conflicts are touched, because—as Federn has shown—he knows his conflicts. The use of language, important for the development of any relationship and for establishing transference in neuroses, can only be a hindrance in treating schizophrenics. We know cases

which show clearly that the schizophrenic does not want to understand our language and changes his own language in such a way that we cannot understand him.

If we want to establish contact with the patient, we must avoid all topics which require abstract attitude; we must proceed in a concrete, direct way, in careful consideration of the patient's ideas, desires, tendencies, etc. and avoid all conflicts as much as possible. The physician's behavior must make the patient feel that there is not so much difference between his world and our world, that he is not so much in opposition to the latter. Thus, he does not have to be afraid of us. Only then may contact with the physician become less dangerous. The patient may thus give up his withdrawal, at least in certain situations, and even be ready to talk about his problems and to accept the help of the therapist.

This is a very crude description of the difficulties in the development of transference in schizophrenics, but it may highlight the essential points necessary for understanding and helping overcome them. It is an extremely difficult job. It requires not only knowledge, endurance, and courage but also deep devotion to one's work. I believe the successes of Klaesi, Frieda Fromm-Reichmann, Rosen, and others to be the result of such procedure. When Rosen stresses the necessity of almost continuous proximity and attention to the patient, this corresponds to our concept of the basis of transference in

schizophrenics. Frieda Fromm- Reichmann's description of procedure indicates that it is similar even in details to that we apply in treatment of organic patients.

From our point of view it is understandable that one of the main points of the clinical setting of psychoanalysis—the physician sitting behind the patient who lies on the couch—is contraindicated. Only by looking at each other can patient and physician come as close to one another as is necessary. Free association should be avoided, as it is apt to increase rather than reduce the disturbance in thinking. The physician should make the patient understand why his behavior, which might have been necessary before, is no longer necessary when he has a closer contact with our world. That means a *certain neglect of the contents*, which have often been put too much in the foreground. Frieda Fromm-Reichmann stresses that: "The actual role of the therapeutic use of the contents of the schizophrenic manifestations has undergone considerable change." Much more important is the genesis of the dynamics which determine the contents of the schizophrenic productions.

In respect to the problem of contents, I am in agreement with Ferenczi, Reich, Rank, F. Alexander, Frieda Fromm-Reichmann—all of whom emphasized that it is not necessary to reach all "repressed" experiences. Alexander says that eliciting memories by free association may be less the cause of the therapeutic progress than its result. I do not wish to imply that

recollections of previous experiences and conflicts are not important; I believe, however, the attitudes are often more important than the contents, a fact stressed first by Max Friedemann.

Freud considered the transference in neurosis a spontaneous occurrence, an expression of the neurosis of the patient, of his pathological desire for an intensive active relationship with the analyst. It is regarded especially as an expression of the drive of repetition compulsion. The patient feels forced to experience again the difficulties of the relationship between infant and parents, by which procedure he shifts his affect against his parents to his analyst. This displacement enables the patient to become aware of the conflicts and to learn to cope with them under the protection of the therapist. Thus, transference neurosis appears as necessary for treatment. In the development of the theory, the physician's active role in the development of transference was increasingly stressed.

It is the first purpose of the therapy of neuroses to bring to light material the patient cannot remember under normal conditions but the knowledge of which is important for the understanding of the origin of the symptoms; the second is to help the patient regain his health. Often the first purpose was considered the most significant. No matter how correct that may be, the second purpose seems to have at least the same, and perhaps greater importance: to help the patient transform his personality in such a way that

he will be able not only to get rid of old conflicts but to handle new ones. What should the patient-physician relationship be like in order to fulfill these tasks?

In my attempt to answer this question I would like to start from MacAlpine's description of the structure of the analytic situation, despite the fact that not all analysts will agree with her and some may consider her description exaggerated. When we wish to understand a phenomenon, an extreme appearance often shows its structure particularly clearly. MacAlpine states that it is impossible for the patient to live in the setting to which he is exposed by the analytic technique. This setting forces him to regress to an infantile level—he responds to the deprivation of object relations by the situation through curtailing the "conscious ego function," thus giving himself over to infantile reactions and attitudes determined by the pleasure principle. The author even goes so far as to assume that in this situation the patient loses not only object relations but the objective world, all his actions in and out of the analytic sessions being imbued with infantile reactions. I would like to stress that this state may also exist more or less apart from the analytic sessions. In other words, the whole personality, the patient's whole life is involved. I cannot discuss here the questions of whether this description fits the condition of transference in general, whether it corresponds to Freud's concept, whether this condition develops spontaneously or is the effect of neurotic trends, whether it is more or less unwillingly produced by the

analyst or develops independently out of the whole situation. I would like to confine myself to some essential remarks.

The first concerns the problem of regression. On another occasion I came to the conclusion that there is no justification for assuming such a regression from the phenomena which gave rise to its assumption. They can be described without it and even in a better, less biased way. I have tried to show that the similarity between the behavior of an infant and a grownup in the situation described becomes understandable as an expression of the process of isolation with which we are dealing in both conditions: in infancy, due to the lack of development of the conscious behavior, and, in the situation in which we are interested here, due to the artificial state of mind the patient is in. Isolation abnormally strengthens the phenomena belonging to the level of awareness (p. 312). To this state belong such experiences as attitudes, feelings, deviations from the normal functions, particularly a prevalence of directly stimuli-determined reactions which produce elimination of the disturbing effect of stimulation and which are experienced as release of tension—in other words, reactions corresponding to the pleasure principle, ambivalent reactions, etc.; they are all due to modifications of functions characteristic of *behavior in isolation in general*, not only of that in infancy. Closer observation shows further that the similarities to infant reactions are merely superficial. The contents of the behavior may differ essentially from that of the infant, and when they appear similar—for example, in verbal

expressions—the words, as closer analysis will show, may mean something very different from what they meant in childhood. The tendency to compare the behavior of adults in pathological conditions to that of children or animals has produced great confusion in the interpretation of symptoms in organic pathology and is only too apt to do the same in the interpretation of neuroses. Patients show deviations from normal conscious behavior above all because the different techniques which Freud has proposed—free association, report of dreams and daydreams, etc.—are particularly apt to produce a state of "isolation."

Even if it were possible to bring the adult into an infantile state, which, as MacAlpine says, concerns the whole personality, we wonder whether this condition would be useful for therapy. We could not be sure whether what the patient utters is important for his present conflict and his neurosis. Furthermore, how could anything be gained in such a state but an idea of what happened to him before? How can he realize what it may mean to him *today*, in a mental state in which just that capacity is reduced by which this decision could be made? One may think that some improvement could be achieved by a form of acting out of partial conflicts which come to the fore. But is that real improvement? I think acting out has no positive value for the cure, however important it may be for release of tension in certain stages of treatment and for facilitation of further therapeutic procedures. It is decidedly unsuited to eliminating the present conflict because it cannot help

the patient reach an adjustment to those remaining conflicts which cannot be eliminated; the patient cannot acquire the new orientation which is an essential part of psychotherapy in cases where *restitutio ad integrum* is not possible, or in neuroses where such a restitution is hardly ever achieved.

Important as the aftereffects of previous—particularly infantile—experiences may be for the development of the present neurosis, the conflicts with which we deal in neuroses can be understood only if we consider the total situation in which the individual is now. The patient must not only become aware of previous conflicts and the anxiety connected with them but must also understand their origin, in particular that they were unavoidable at the time of infancy but that they no longer apply to the present situation, however much he may feel the anxiety related to them. He must realize the present conflict and its significance for his self-realization now and in the future, he must see which conflicts can be eliminated and which cannot. How could the patient, in a state of transference as described by Mac- Alpine, find a new attitude toward himself and toward the world, and make his choice according to a value system which corresponds to his total present situation? The patient will be able to do that only if he can face the problems he has to deal with—in other words, if his attitude toward them changes from anxiety into fear. It is one of the paramount tasks of psychotherapy to help the patient to accomplish this change, and for that he must make use of his abstract capacity which is preserved in the normal part of his personality. That could

not be achieved in an infantile state.

One might think that this transformation of the personality could take place in a second stage of therapy, after the infantile material has first been brought to the fore. But such a distinction between two separate stages does not correspond to the facts. Some infantile conflicts, emotions, and attitudes related to definite experiences may be remembered and lived through with emotions and intellectual insight. But during one and the same period of treatment the patient passes alternately through different stages—always the one which corresponds to the tasks he has to fulfill —just as does a normal person. Sometimes ambivalent emotional reactions are quite incorrectly called childish, i.e., regressed. They likewise belong to normal, adult life situations. If such a state of "regression" occurs in treatment, many of the difficulties of abnormal attitudes, aggressiveness, or love toward the therapist may arise. The dependence on the analyst may become so strong that one could fairly speak of a special kind of neurosis with the characteristic fixation and ambivalence. This situation should be avoided, and this can best be achieved through the organization of the patient-physician relationship which corresponds essentially to the presupposition for treatment of organic patients and schizophrenics: the patient-physician communion.

I consider such a relationship the presupposition also of the development of a transference neurosis. Without it the patient will not be

willing to regard his contact with the therapist as a father-son relationship. On the other hand, I do not consider it necessary that an outspoken transference neurosis take place, although I do not mean that recollection of the parental relationship and a correspondingly ambiguous attitude toward the physician will not or should not occur at all.

I find it gratifying that my experiences correspond to those of some well-known psychoanalysts, for example, Franz Alexander when he says: "The emphasis is no longer on transference neurosis, the transference relationship becomes the axis of therapy," and when he further stresses that "the therapist should always be in control of the transference neurosis, avoiding a more extensive neurosis and restricting the growth of it to those facets which reflect the conflict."

The structure of the state of communion, in my opinion the basis of all treatment, leads us to understand why the difficulties with which one is often confronted in transference neurosis either do not occur in this condition or occur mildly. One of the significant causes of the usual difficulties is the fact that the patient is isolated from the physician, who, so to say, remains out of the game. Consequently, the patient is always afraid to lose the therapist's protection and reacts to the situation in a "primitive" way, as we all react in anxiety—that is, he adopts the pleasure principle and clings to the physician by all available means.

It is not only the person of the therapist on whom he depends abnormally but the idea that improvement will come from the outside, from a kind of powerful God or doctrine which the physician represents and which alone can cure him. This is expressed by the patient's attempt to use analytic interpretation and terminology, a practice which can prevent him from seeing the facts. He cannot consider discontinuing treatment; he cannot accept another therapist; he will consider the slightest deviation from what he has learned with disbelief. In other words, he does not become free; he does not learn to master his conflicts himself—the requisite for regaining health.

These difficulties can only be avoided if, from the very beginning, the relationship is arranged so that the patient experiences it as a common enterprise of himself and the physician, in which the latter is leading only because he has learned how to handle difficult problems, but which will be successful only when the patient shows good will and participates in the procedure.

This feeling of a common enterprise presupposes the development of communion. Only in this condition can the communication take place which is necessary to make the patient aware that his problems are not alien to the therapist, that they are common more or less to all human beings, that—however different the symptoms may be by which they are recognizable—they arise basically from the disruption of the mutual relationship between

him and others, the basis of all human existence. He learns further that human existence —self-realization—always necessitates some sacrifice, which need not be taken as an expression of a positive value but as the price man has to pay for being an individual.

This valuable experience of the significance of mutual human relationship, which he has realized in the transference situation, he will take away with him when, later on, he has to live without direct contact with the therapist. He will no longer need the physician as a person; the mutual relationship between patient and physician—whether or not they later meet again—will never cease. This experience is important in that it can shorten the time of treatment, but perhaps as important is the fact that it is still effective after the treatment has ended.

If one considers the development of the state of communion a first requisite in therapy, many psychoanalytic procedures which have been treated rather like sacraments are affected. I will mention primarily the attitude toward the use of the couch as one of the most disputed procedures. Organismic technique states that the patient should not lie down on the couch before development of communion. Further, our method of approach influences the number of sessions per week, the duration and cost of the treatment, the relationship between the patient and the physician outside the consulting room, and after the end of the treatment, the relationship of the

physician to the patient's relatives, and his communication with them, treatment of both husband and wife—not together but at the same time—when family problems, particularly sexual ones, are involved.

The principle of communion as a prerequisite of treatment does not imply that the patient and the physician play the same part.

With organic patients, the physician is the guide and careful observer during the whole treatment—and afterward in so far as he helps the patient to organize life in the future. But the patient must not play a passive role; he must understand that he has to be active, must learn to bear difficulties for the sake of the best form of self-realization.

In the case of schizophrenia, the physician should at first obtain complete control, but so imperceptibly that the patient will be encouraged by experiences to cooperate and to participate in the attempt to overcome the difficulties. It is important that the physician alternate in his attitude toward the patient— remaining passive when he feels that his activity touches conflicts the patient is not yet ready to bear, and becoming more active when that is possible. He should at the same time be in close contact with, and keep his distance from the patient. Important as it is that the patient feel his closeness to the physician, the latter must not show more affection than the patient is able to bear at that moment.

In the case of neurosis, the patient should be induced to participate in the procedure from the beginning. When free associations are used, particularly in relation to dreams, it should be done only periodically; long periods of free associations should be avoided, the patient should again and again be brought back to reality, and a synthesis of the results achieved should be attempted. The relationship of the patient to the physician should never be merely passive; a friendship should develop which might last after treatment during long periods of life.

Let me conclude with some general remarks about the phenomenon of communion (cf. Ref. 7). It is not easy to describe what is understood by this term. One must experience the state in order to realize what it represents. It is an example of the frequently discussed "We" experience—or Buber's "I-Thou" experience—which we undergo, as has been said, without an act of reflection. One could call it the experience of a unity of individuals—a unity which does not eliminate them as such but on the contrary promotes their full development. It disentangles the individual from many irrelevant experiences and from many conflicts of the past and present, it makes him free to realize the essentials of life in general and of his individual existence in particular, the basis of self-realization.

We consider communion as the presupposition for every successful treatment, precisely because, in such a situation, we arc dealing with an

expression of one of the fundamentals of human existence, the possibility of understanding and accepting each other. The union is based on the normal drive in man to help and to be helped out of which originates the mutual concern and thus the guaranty of self- realization in the highest possible degree for the particular individual and the "other."

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