

*INTERPRETATION OF SCHIZOPHRENIA*

**The  
Psychotherapeutic  
Approach to  
Schizophrenia:**

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# **The Psychotherapeutic Approach to Schizophrenia:**

*A Historical Survey*

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## **Table of Contents**

[The Psychotherapeutic Approach to Schizophrenia: A Historical Survey](#)

[I Freud and the Freudian School](#)

[II The Kleinian School](#)

[III Sharing the Patient's Vision of Reality](#)

[IV Frieda Fromm-Reichmann and Her School](#)

[V Miscellaneous Contributions](#)

[Bibliography](#)

[Acknowledgments](#)

## The Psychotherapeutic Approach to Schizophrenia: A Historical Survey

Although the majority of schizophrenic patients all over the world are treated with physical therapies, the number of those treated exclusively or partially with psychotherapy is rapidly increasing. At the present time, no psychiatrist can ignore individual psychotherapy of schizophrenia, nor can he escape practicing psychotherapy with schizophrenics even if he is inclined to do so. Even a psychiatrist whose practice consists predominantly in administering phenothiazines cannot help inquiring about the dynamics of the patient's anguish and conflict, cannot help observing and interpreting what happens between the patient and himself. He may not apply all the insights that people who have devoted themselves to the psychotherapy of schizophrenia have communicated, nor follow all their recommendations, but some of them have rubbed off on every psychiatrist. What Frieda Fromm-Reichmann, other pioneers, and we, their followers, have tried to do has not been ignored, but assimilated, even if at times in very diluted forms. Moreover, even those who have enlarged the field of psychotherapy to include family therapy, group

therapy, and community psychiatry have built upon the foundations laid by individual psychotherapy. The study of human groups can add to, but not replace, the study of the individual.

Individual psychotherapy of schizophrenia is still in the pioneering stage, in spite of gigantic steps made in the last few decades. This treatment is not yet fully integrated and not entirely understood, because the “pioneers” and their followers have used different methods or have given different interpretations to their approaches. Generally, the fundamental premise to any type of psychotherapy of schizophrenia resides in the notion that psychological factors and psychological mechanisms constitute at least an important and necessary part of the etiology and/or symptomatology of the disorder. A collateral assumption is that even if some important aspects of schizophrenia are not based on psychological factors, a therapeutic intervention in the psychological part of the disorder will engender changes sufficient to remove or at least ameliorate the condition and in many cases prevent its recurrence.

In this chapter we shall review the main methods in their basic

aspects and techniques. Space limitations will require that we omit secondary methodologies and procedures. It is possible to recognize that each method adopted in the psychotherapy of schizophrenia is the clinical expression or the therapeutic realization of one or few underlying principles held by its originator. Often the principle was deduced from the clinical experiences of the therapist; in some instances a preconceived theoretical view oriented the therapist in certain directions.

## I

### **Freud and the Freudian School**

Any review of the psychotherapy of schizophrenia must start with Freud. And yet, paradoxically, Freud, to whom we owe so much for the understanding of many aspects of this disorder, discouraged psychotherapy with schizophrenics. To be exact, as early as 1905 he did not consider the obstacles to be insurmountable in the future and did not exclude the possibility that some modified techniques would be devised that would permit the psychoanalytic treatment of the psychoses (Freud, 1905). Later, however, Freud assumed a more pessimistic attitude. He felt that the psychosis could be compared to a

dream and understood as a dream, but that it could not be cured.

An underlying principle was at the basis of his pessimism. As we have seen in Chapter 2, Freud believed that in schizophrenia there is a withdrawal of libido from the objects into the self; therefore no transference can take place, and without transference no treatment is possible. He said that in “narcissistic neuroses” (that is, psychoses) “the resistance is unconquerable.” The technical methods of psychoanalysis must “be replaced by others; and we do not know yet whether we shall succeed in finding a substitute” (Freud, 1924a, *b*). Several years later (1938 *b*, 1940) he reiterated that in psychoses the instinctual component is too powerful to be overcome by available psychoanalytic methods of treatment.

The basic distinction made by Freud between transference neuroses (psychoneuroses) and narcissistic neuroses (or psychoses) was maintained by classical psychoanalysts, and the psychotic patient continued to be treated with the methods of traditional psychiatry. To my knowledge, Freud never treated schizophrenic patients, although he did treat some manic-depressives.

Even Abraham, the distinguished pupil of Freud, who did so much pioneering work in the treatment of manic-depressive patients, had for a long time a negative attitude toward the treatment of schizophrenia. He wrote that “dementia praecox destroys a person’s capacity for sexual transference, i.e., for object love” (1908). He considered “the negativism of dementia praecox as the most complete antithesis to transference.” Later Abraham (1913, 1916) changed his views and considered transference with schizophrenic patients possible. His contributions to this area, however, were modest and were by far inferior to his contributions to the treatment of depressed patients.

Another one of Freud’s early and famous pupils, Paul Federn, made repeated and successful attempts to treat schizophrenic patients, in spite of the prevailing discouraging theories (1943, 1952). One of Federn’s underlying principles was based on the concept of ego-feeling, or of an autonomous reservoir of libido in the ego. He felt that the ego of the schizophrenic is poorer, not richer, in this libido, contrary to what Freud’s theories implied. He also felt that transference with the schizophrenic was possible; and as a matter of fact he succeeded in establishing it with several patients. Another

tenet of Federn (that of the ego boundaries), however, limited his therapeutic aims. Federn believed that in the schizophrenic “the boundaries” separating the areas of the psyche (the id from the ego and the ego from the external world) are defective, so that material from the id may invade the ego and even be projected to the external world. The most important goal of therapy should be that of establishing normal boundaries. Reversing a famous sentence of Freud’s, Federn said that as a result of therapy in the schizophrenic, “there where ego was, id must be.” He did not mean that the id should be liberated, but that it should be put back into what he believed was its proper place, a state of unconsciousness, repression, and control. The normal resistances that the psychosis has broken down should be reestablished. To do so the classic technique has to be changed in many ways. One of the changes consists of having the help of another person, generally a woman, who takes care of the patient between sessions and especially during the periods of negative transference. The usual technical procedures (free associations, analysis of the positive transference, institution of transference neurosis) should be abandoned because they lead to a “transference psychosis” in which the analyst becomes a persecutor. The resistances that maintain

repression should not be analyzed. The phobias should be left untouched “because they protect deeper fears and conflicts.”

Federn relied on the healthy or mature part of the patient, on the remnants of the normal ego, to combat the sick part. He believed that at first the psychoanalyst should share

the acceptance of the psychotic’s falsifications as realities. He shares his grief and fears and on this basis reasons with the patient. When convinced that by this procedure the patient feels himself understood the analyst presents the true reality as opposed to falsification. He then confronts the patient with his actual frustration, grief, or apprehension, and connects this with the patient’s deeper fears and conflicts and frustrations (Federn, 1943).

It is apparent that for Federn psychoanalytic treatment of schizophrenia should consist of a symptomatic repression of the id; of restoring the defective ego boundaries. *Render to the id what is id’s*. Do not allow it to remain confused with the ego. Federn thus did not tackle the psychotic part of the patient’s personality.

A nurse who was analyzed by Federn, Gertrude Schwing, applied her analyst’s concepts to hospitalized patients. In a straightforward

and honest, but not fully convincing book, *A Way to the Soul of the Mentally Ill*, Schwing (1954) describes the schizophrenic as a person who has been deprived of the experience of having a real mother, a person who loves her child at any cost. The psychiatric nurse must offer that love to the patient. Schwing describes several techniques that establish continuity of contact with the patient and stresses the point that the patient must have the feeling that this new mother is there and does not intend to abandon him. Schwing considers her treatment a preliminary one, to be followed by Federn's method.

Leland Hinsie is one of the American pioneers in the psychotherapy of schizophrenia. As early as 1930 he published a book devoted to this topic. He studied adolescent patients who voluntarily sought treatment and who had insight into the fact that they were sick, and were communicative and willing to follow the directions of the therapist. Thus Hinsie selected the easiest patients to treat. He relied predominantly on the clinical psychoanalytic method of "free association" and theoretically remained faithful to the classic Freudian theory (Hinsie, 1930).

Within the Freudian school we must also mention the works of

Waelder (1925), Clark (1933), Jacobson (1967), and Arlow and Brenner (1969).

The ego psychologists within the Freudian school, with the exception of Eduardo Weiss, have not followed the ego psychology of Federn, but rather that of Hartmann (1950a, *b*, 1953, 1956, 1964), Rapaport (1951, 1958, 1960), and Hartmann, Kris, and Loewenstein (1945). Although these authors have acknowledged that schizophrenia is predominantly a disorder of the ego, their practical impact on the psychotherapy of schizophrenia is not discernible so far.

## II The Kleinian School

Melanie Klein studied the earliest infantile levels of development, and her findings were soon applied to the study and treatment of the psychoses. Her writings and those of her pupils are somewhat difficult for readers not accustomed to her terminology and her general theoretical frame of reference.

According to Klein, even at birth the ego is organized sufficiently to experience anxiety, to build defense mechanisms, and to form

primitive object relations both in real life and in fantasy forms. As a defense against an overwhelming anxiety of annihilation the ego develops the capacity to introject and to project. In the paranoid-schizoid position, which occurs during the first four or six months of life, anxiety is experienced as persecutory in nature. According to Rosenfeld's (1969b) interpretation of Klein, this way of experiencing anxiety contributes to certain defenses, "such as splitting off good and bad parts of the self and projecting them into objects, which through projective identification became identified with these parts of the self." This process is the basis of narcissistic object relationships. If the child does not proceed normally to the next phase of development, which is the depressive position, the earlier persecutory fears and schizoid phenomena return and are reinforced. This is the basis for schizophrenia later in life.

A fundamental point of view advocated by Klein's pupils Rosenfeld, Segal, Bion, and early Winnicott (1945) is that no modification of the classic Freudian psychoanalytic technique is needed in the treatment of psychotics. Winnicott later changed his views and came to attribute great importance to environmental factors. Rosenfeld, Segal, and Bion have instead maintained strict

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

Rosenfeld has made important contributions, many of which have been collected in one book (1965). In 1947 he reported the office treatment of a schizophrenic patient suffering also from depersonalization. Rosenfeld at first found the patient's "narcissistic withdrawal and ego disintegration an insoluble problem," but then he became aware that the patient was using schizoid mechanisms against painful feelings in the transference situation. The patient had lost her feelings and believed she had lost herself. Rosenfeld interpreted her experiences as due to a process by which parts of her self were split off and projected into the analyst. The patient also felt that she was intruding inside the analyst and losing herself there. This experience made her develop projective paranoid anxieties of being intruded and overwhelmed by the analyst. Rosenfeld interpreted the patient's withdrawal as partly a defense against paranoid fears and partly a defense against closeness and intrusion.

In reporting the case of the treatment of a hospitalized acute

schizophrenic, Rosenfeld (1952a, b), “while acknowledging the importance of the analyst’s intuitive understanding of the patient’s communications, . . . thought that the analyst should also be able to formulate consciously what he had unconsciously recognized and to convey it to the patient in a form that he can understand.”

Later Rosenfeld (1954) reported “that the psychotic manifestations attached themselves to the transference in both acute and chronic conditions, so that what might be called ‘a transference psychosis’ develops.” By stressing the concept of “transference psychosis” Rosenfeld did not merely reintroduce one of Federn’s concepts. Contrary to Federn, Rosenfeld felt that the transference psychosis should not be avoided, is indeed analyzable, and should be worked through by means of interpretation.

Recently, Rosenfeld (1969a) has described a number of projective identifications that occur in the treatment of psychotic patients. He distinguished the following processes:

1. Projective identification, used by patients for communication with other objects, that seems to be a distortion or intensification of the normal infantile nonverbal relationship between infant and mother.

2. Projective identification used to rid the self of unwanted parts.
3. Projective identification aimed at controlling the analyst's body and mind.
4. Projective identification used predominantly to deal with aggressive impulses, particularly envy.
5. Patient's belief that he is living entirely inside the analyst and behaves like a parasite using the capacities of the analyst, who is expected to function as his ego.

Rosenfeld stresses that in the treatment of psychotics it is essential to differentiate these projective parts of the self from the saner parts, which are less dominated by projective identification. These saner parts are in danger of submitting to the persuasion of the delusional self. Although he stresses the fact that these saner parts are not adult but "more normal non-omnipotent infantile parts of the personality," he finally seems to get closer to the views of Fromm-Reichmann and myself in seeming to agree that the nonpsychotic parts of the patient have to be summoned in the fight against the psychosis.

Segal (1950) reported the treatment of an acute schizophrenic patient. She felt that all material, heretofore unconscious, should be

interpreted to the patient at the level of the greatest anxiety. She felt that schizophrenics tolerate the conscious state of thoughts and fantasies generally kept repressed by the neurotic. They repress, however, the relations between fantasy and reality. Segal believes that by giving reassurance and sympathy to the psychotic patient, as many analysts do, the analyst temporarily becomes the good object, but at the price of enhancing the split between good and bad objects and reinforcing the defenses, so that later the negative transference will assume unmanageable proportions.

Bion made important studies on the meanings of the patient's communication (1954) and on the role of projective identification in the psychotic part of the personality as a substitute for repression in the neurotic part of the personality (1957). In describing the transference of the psychotic he said, "The relationship with the analyst is premature, precipitated, and intensely dependent" (1956).

With the exception of Winnicott, all important pupils of Klein reassert their adherence to the classic psychoanalytic method, without major alterations to fit the psychotic. Kleinian conceptions have acquired prominence in England but also in South America and

especially in Argentina.

### III

## Sharing the Patient's Vision of Reality

Some significant psychotherapeutic methods, although originated from different theoretical premises, have the common aim of making the therapist enter and share the patient's vision of reality.

John Rosen originated his method in 1943. At the suggestion of Federn (1947) he called it "method of direct psychoanalysis." Whereas the usual or indirect psychoanalytic approach establishes communication with the patient through the ego, Rosen's treatment aims at communicating directly with the unconscious, presumably with the id or with "ego-states of infancy and childhood" (Federn, 1947).

As we have seen earlier in this chapter, Federn also thought that a transference psychosis may occur in the treatment of the psychotic, but whereas Federn felt that it had to be avoided, Rosen makes of it the major tool of therapy. Other people, like Rosenfeld and the Kleinian school in general, analyze the psychotic transference with the

traditional indirect method; Rosen uses a direct method. During his early period (1943-1945) Rosen worked with severely ill patients at Brooklyn State Hospital and at the New York State Psychiatric Institute and published his first results in his book *Direct Analysis: Selected Papers* (1953). In his early writings Rosen described his technique without formulating a major theoretical foundation. He gave abundant interpretations to the patient, which were communicated in a vivid and shocking language that conveyed what Freud's early papers attributed to the unconscious. Such explanations as, "You want to screw your mother, kill your father," "You want to sleep with me" were quite frequent. During this period most of Rosen's interpretations were based on the expression of a previously repressed sexuality that was Oedipal in origin.

Repressed sexuality, however, was not the only pathogenic area. Rosen believed also that the schizophrenic is the victim of a mother who had suffered from "a perversion of maternal love," and tried to offer to the patient what he did not have. The patient must experience in the therapist a powerful, protective, benevolent person, as he wished his mother had been in his early childhood. The therapist at times must assume the role of the persecutor and try to convince the

patient that he will have a beneficial rather than a persecuting effect. The analyst must spend a long time with the patient—up to sixteen hours a day—and, like Federn, must often resort to an assistant. The patient is showered or shocked with the interpretations. Such overwhelming, all-embracing treatment would often solve the acute episode in a few weeks and had to be continued by the second stage of treatment, which follows a technique more similar to classic psychoanalysis.

During the specific, or first, stage of treatment the analyst enters the psychotic world of the patient, who immediately feels better because he is finally understood. The therapist should not even avoid becoming one of the imaginary persons who appear in the delusions. Later (1953-1956) Rosen developed the theoretical view that there are no separate psychoses as disease entities but only phases of one psychosis. He wrote that “the same patient may pass from paranoia into hebephrenia or from manic-depressive psychosis into obsessive-compulsive neurosis, right before our eyes” (1964).

In what he calls the third stage (1956-1961) of the evolution of his treatment, he established in Philadelphia the Institute for Direct

Analysis. Among the techniques developed there were the setting up of a treatment unit for the individual patient; the use of helpers (assistant therapists), as Federn had already done; and the establishment of the total care of the patient. During the final fourth stage Rosen published his book *Direct Psychoanalytic Psychiatry* (1962), in which he illustrated all his currently held therapeutic techniques and theoretical views.

I have witnessed a few of Rosen's therapeutic sessions, and I was impressed by the technique with which he was able to establish contact with the psychotic. The male patient who was told that he wanted to screw his mother or kill his father and the female patient who was told that she wanted to sleep with Rosen were both touched inside by these verbal shocks and unexpected attitude. They broke their barriers, started to communicate, and soon would lose their delusional thinking. I was very doubtful that the improvement would last. As a matter of fact, I heard from various sources and from Rosen himself that, contrary to his early expectations, relapses and progression of the illness occurred.

I felt, however, that to establish such a rapid contact and

relatedness with a patient who was refractory to such relatedness was no little accomplishment. I felt during my observation of the way Rosen operated that somehow he succeeded in introjecting himself and almost hypnotizing the patient. In my opinion the presence of a large audience during the session was important. Somehow I felt I was participating in a primitive ritual. Rosen was the shaman or the magician. We in the audience were the clan or the tribe, giving authority and power to Rosen. The combination of the direct method and of the collective ritualistic atmosphere made the patient receptive to introjection.

I also tried to understand some of Rosen's techniques. For instance, if he said to a female patient, "I am going to sleep with you tonight," he did not want to shock her. Of course Rosen did not intend to act in accordance with his statement, nor did he intend to lie to the patient. Rosen feels that in the language of the unconscious wishes and promises have the value of reality. By making the patient wish, he was giving immediate gratification to the deprived patient. In the unconscious a wish that is not fulfilled is not necessarily a frustration, it becomes fantasied reality.

It is worthwhile to give a rapid look at Rosen's theories. After the very first period, where sexuality played the preponderant role, he developed the concept of "early maternal environment." According to Rosen, for the child "mother" equals environment. "Mother" is an entity that includes not only the mother herself and what she does or fails to do in her maternal role, but also other people and what they do or fail to do. This concept of early maternal environment expands Rosen's previous concept of the "perversion of the maternal instinct" in the etiology of schizophrenia. If this early maternal environment possesses many negative qualities, it may become the chief cause of the disorder (Rosen, 1963).

Another important concept of Rosen's is his own modification of the Freudian superego. The superego is not "the heir to the Oedipus complex" but "the psychical representation" of the whole early maternal environment. Commenting on the fact that Freud was surprised because "the superego often develops a severity for which no example has been provided by the real parents," Rosen stated that the phenomenon is not surprising at all: the total early maternal environment may be worse than the patient's parents.<sup>[1]</sup>

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

Rosen's fourth basic concept is that of transference, which is not interpreted in a classic Freudian way. For Rosen transference is a variety of the tendency to "seek the mother you knew." Rosen adds: "The individual cannot find the mother he knew, so he tries to make whomever is available at the moment into the one he seeks by prodding, picking, cruelty, trickery, seductiveness, and gift-bearing. And finally, if all this fails, he actually projects onto the person in question the qualities and attitudes he is seeking. Thus transference consists of a transformation of the nonmaternal into the maternal."

Whereas early in his career Rosen relied more on the shocking effects of his interpretations, later he came to see the role of the

therapist predominantly as one of “foster-parent.” The unit in which the patient lives during the treatment is a foster home. There the patient will find compensation for the inadequacies of the early maternal environment.

Rosen’s method has been the object of much criticism. Even his admirers point out the fragility of his theoretical framework and attribute his therapeutic successes to his personal qualities: lack of hostility, perseverance, physical endurance, and so on. Others feel that the interpretations he gives the patients are arbitrary, not even necessary, and that his success was due simply to the fact that he was able in some way to establish contact with the patient. Others (Horwitz et al., 1958) doubt even his results. They state that his claims of many recoveries were exaggerated; that some of his patients were misdiagnosed; that others who were undoubtedly schizophrenic had relapses and were later treated with physical therapies.

I too feel that Rosen’s early assertions, like those of any pioneer, suffered from excessive enthusiasm. Also, some of the theoretical bases of his technique are unsubstantiated. Nevertheless, it is beyond question that Rosen obtained at least temporary results and that he

was able to inject faith into many workers at a time when the prevalent opinion was that psychotherapy with schizophrenics was an impossibility.

He continued to pursue some avenues opened by others: for instance, the use of the therapeutic helper, introduced by Federn. In many other ways he has been a creative innovator. Some of his theories reaffirm in different language the importance of the mother in the early life of the patient and of the early environment in general. On a theoretical basis he has never tried to interpret why and how at a certain period in the life of the patient, “this seeking the mother the patient knew” is done through the media of the primary process.

Worthwhile works on the method of direct analysis, in addition to Rosen’s, are the writings by Brody (1959), English et al. (1961), and Scheflen (1961).

The Swiss psychologist Marguerite Sechehaye also believed that the world of the psychosis can be entered by the therapist with her method of “symbolic realization” (1956). In her theory and practice she accepted much of the classic psychoanalytic and existentialistic

approaches but added many innovations. In her method the actions and manifestations of the patient are not interpreted to him but *shared* with him. Of course, the therapist must formulate in his own mind interpretations of what the patient means or experiences. He resorts to his psychoanalytic experience, to his knowledge of the life history of the patient, and to his own intuition. Sechehaye's method aims at helping the patient to overcome the initial traumas of his life by offering him a level of interpersonal relations that is corrected and adjusted to the weak state of the psychotic ego. The patient is able to relive the unsolved conflicts of his early life and to solve them, or at least he becomes able to gratify some of his primitive needs. For instance, by giving her patient Renee apples (symbolic of the maternal breast) Sechehaye allowed the patient to relive an early trauma and permitted a magical gratification of an oral need. Once the meaning of the patient's symbols are understood by the therapist, he uses them repeatedly in order to establish communication and also to transform reality to a level that the patient can accept without being hurt or traumatized.

What Sechehaye tries to accomplish can be seen as the staging of a dream in waking life. As in dreams, symbols replace objects as they

appear to the waking mature ego, and gratification of primitive needs takes place. Sechehaye thus enters the dream of the psychosis by creating an artificial and curative dream that eventually will lead to a healthy awakening.

Sechehaye's technique is difficult to practice. Is it really possible in the majority of cases to set up an artificial dream that uses the symbols that belong only to a specific patient? A certain capacity for intuition is necessary, and this manifests itself after contact is made with the inner core of the patient. Such capacity is not reducible to, or deductible from, rules or instructions or theoretical premises to be found in Sechehaye's method (1956).

Sechehaye devoted two books to her treatment of her patient Renee, whose case perhaps remains the best reported in the literature (1951a, b). She lived with the patient and spent many hours every day with her. One wonders whether the remarkable improvement she obtained was based on "symbolic realization" or on her generous giving of herself. Using Rosen's terminology we could say that certainly Sechahaye made up for the defects of Renee's early maternal environment. It is more than doubtful that such treatment is

applicable on more than a very small number of patients.

Ronald Laing's method is difficult to describe because in spite of the author's many writings it has never been reported in the literature. In his first book, *The Divided Self* (1960), he insisted on examining the existentialistic despair, the division of the patient's psyche, his "ontologic insecurity." In his later writings Laing not only shares the psychotic world of the patient, but he supports it. He feels that the patient is correct in blaming his family and the environment. He had to live in an unlivable situation; he really was persecuted, was labeled "psychotic," dismissed from the human community. The method helps the patient to reassert and accept himself and to reevaluate his position within the society in which he lives. Laing relies very much on family therapy also (Laing and Esterson, 1965).

## IV

### **Frieda Fromm-Reichmann and Her School**

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

Sullivan is very well known for his theoretical innovations in psychiatry in general and schizophrenia in particular. People who have worked under him have attested to his therapeutic successes. Unfortunately his premature death prevented him from reporting in writing his technique. Mullahy (1967, 1968) has given us not only a lucid exposition of Sullivan's theory of schizophrenia but also a succinct account of his therapeutic innovations. Mullahy reports that as director of clinical research at Sheppard and Enoch Pratt Hospital, Sullivan stressed to his assistants the importance of the first twenty-four hours on the ward for any patient. Life on the ward was more important than the daily session with the therapist, and Sullivan encouraged his assistants to spend a great deal of time with the new patient in a close and reassuring relationship. In one of his early papers, Sullivan (1931) gave a resume of hospital treatment. He instructed the paraprofessional personnel to be aware that an extreme sensitivity underlies whatever camouflage the patient uses. The patient is immediately made to feel that he is one of the group. In this truly human environment a degree of social recovery occurs, and the patient becomes aware of his need for insight.

Mullahy writes that Sullivan attempted a direct and thorough

approach chiefly by reconstructing the actual chronology of the psychosis. Sullivan impressed on the patient that whatever had befallen him was related to his life experiences with a small number of people.

Frieda Fromm-Reichmann worked closely with Sullivan. Unlike him, she became much better known for her therapeutic endeavors than for her theoretical contributions. The value of her therapy received large recognition. Fromm-Reichmann named her treatment “psychoanalytically oriented psychotherapy” and not “psychoanalytic treatment” to emphasize that it constituted a departure from the classic Freudian psychoanalytic procedure.

Fromm-Reichmann’s courage in treating difficult patients, the qualities of her personality, such as her genuine warmth, humility, and exquisite psychological intuition, certainly played an important role in establishing a milieu of therapeutic acceptance of the schizophrenic and in stimulating others toward similar pursuits. In addition to a very insightful book on psychotherapy (1950) she wrote many papers (1939, 1942, 1948, 1952, 1954, 1958) that have been collected and published by Bullard (1959). Nevertheless her ideas on the therapy of

schizophrenia have never been integrated into a systematic whole, perhaps because of a lack of an original theoretical system. For theoretical foundations she leaned on Freud and to a larger extent on Sullivan. Sullivan's idea (1953a) that some degree of the interpersonal relatedness is maintained throughout life by everyone, regardless of his state of mental health, was a basic prerequisite to her attempts to establish transference with the psychotic. Even the schizophrenic disruption is a partial one.

Fromm-Reichmann stressed that it is very hard for the patient to trust anyone, even the therapist; and if the latter disappoints him in any way, the disappointment is experienced as a repetition of early traumas, and anger and intense hostility result. Fromm-Reichmann treated the patient with daily sessions and did not make use of the couch or of the method of free association. She relied much less than other authors on the therapeutic effect of interpretations. She made a cautious use of them, however, and emphasized that the symptomatology is susceptible of many interpretations, all correct, and that at times it is useful to give even partial interpretation.

Fromm-Reichmann was among the first to emphasize that the

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

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

losses but must accept the fact that they can never be made up and that he is nevertheless capable of becoming integrated with the interpersonal world. It will be easier for him to integrate when he recognizes his fear of closeness and even more so his fear of his own hostility. Fromm-Reichmann paid great attention also to the countertransference of the therapist and especially to his anxiety in treating the schizophrenic patient.

In the course of her career, Fromm-Reichmann changed some of her ideas. Whereas in her early papers she recommended complete acceptance of the way the schizophrenic patient is, as sort of compensation for the early injuries, later she wrote that this attitude was not the only way of making the patient overcome his reluctance toward reestablishing personal contacts (1948, 1952, 1954). She emphasized more and more that the therapist must address himself to the adult part of the patient's personality, regardless of how disturbed this personality is.

Fromm-Reichmann thought that only quantitative differences exist between normal, neurotic, and schizophrenic individuals and apparently minimized the fact that quantitative differences bring

about qualitative differences.

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

Among Will's contributions is his insistence that the therapist "define his relationship with his patient, refusing the patient's attempts to avoid such definition by his withdrawal or his insistence that he can never change, that there is nothing the matter, and that the therapist is of no significance to him" (1967). In addition to reporting vivid case presentations of patients treated in a hospital setting, Will has given useful instruction about what he calls "the development of relational bond" between the patient and the therapist. Such development requires: (1) recurrent meetings of the participants; (2) contact of the participants with each other—verbal, visual, tactile, aural, and so on; (3) emotional arousal (1970).

Harold Searles has done extensive writing on the psychotherapy of schizophrenia. In his first book (1960) he showed that the concept

of transference, generally restricted to human object relations, should be expanded to include the nonhuman environment. He has also written many insightful papers that have been collected in one volume (1965). It is impossible to review all of them. They make very rewarding reading, especially for some aspects of the psychodynamics of schizophrenia and of the phenomenon of transference. Searles has described the difficulties of the transference situation: how the patient fights dependence, which would compel him to give up fantasies of omnipotence. He has also shown how the transference situation leads the patient to additional projections. In an important paper (1962) he clearly differentiates between concrete and metaphorical thinking in the recovering schizophrenic patient, although he makes no use of the studies done by other authors on this important subject.

## V

### **Miscellaneous Contributions**

Bowers (1961) applied hypnosis to the treatment of schizophrenia, although the general opinion is that such treatment is not suitable for psychotics. She hypothesizes that in hypnosis the therapist rapidly establishes contact “with the repressed, healthy core

of the patient.” She points out that the problems of resolution of the symbiotic relationship require the utmost skill, but long remissions have been secured. A successfully hypnotized schizophrenic is moving toward recovery, because he is able to reincorporate the other, the therapist, and thus reestablish interpersonal relations.

Benedetti (1955, 1956), an Italian psychiatrist who studied with Rosen and teaches and practices in Switzerland, accepts a great deal of Sullivan and Fromm-Reichmann, as well as some existentialistic concepts. He feels that the two basic tools in the treatment of schizophrenics are sharing of the feeling of the patient and interpretation. Benedetti (1971) feels that high sensitivity, extraordinary need of love, and reactivity above the average level make the patient very vulnerable to schizophrenia. The therapist must understand the request inherent in the suffering of the patient (Benedetti, 1972). The patient wants the therapist to understand his essence, his being the way he is, even if at the same time he rejects the therapist. Society, including therapists, tends to evade the patient’s request by objectifying his symptoms and by not permitting him to make claims.

From an Adlerian point of view Shulman (1968) has described very useful procedures. The therapist must help the patient to make a better rapprochement with life, to avoid the use of psychotic mechanisms, and to change mistaken assumptions. In a very human and compassionate way Shulman describes in specific details how to help the patient through these therapeutic procedures.

The Jungian school has concerned itself mostly with borderline patients or latent psychoses (Baynes, 1949). Tedeschi (1969) states that when archaic archetypal elements appear in the psychotherapy of the patient, the therapist should stimulate the patient's interest in corresponding cultural, historical, and artistic situations that contain the archetypal images. Tedeschi obtained good results by treating a schizophrenic Jewish medical student by reenacting rites from the Old Testament and correlating them to current political events.

### *Notes*

- [1] Apparently Rosen does not attribute any role to the child in creating in his inner life an environment worse than the one of his external reality. For a different point of view see Chapter 5 of this book.

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