ISPS - US Newsletter

United States Chapter of the
International Society for the Psychological treatment of Schizophrenia and other psychoses

"...Innate among man's most powerful strivings toward his fellow men...is an essentially psychotherapeutic striving."
Harold F. Searles (1979)

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From the President:

Report on the Second Annual ISPS-US Conference, Challenging the Port Study, and Plans for the Future

Ann-Louise S. Silver, MD

August, 2001

ISPS-US is enjoying a fundamentally productive year. Our members are building friendships that are strengthening over time. We are looking forward to our Saturday, October 6, 2001 meeting in the same way Washington colleagues anticipated the Chestnut Lodge Symposia, for personal and philosophical reconnection. (There will be no Chestnut Lodge Symposium this year.) Our second ISPS-US annual meeting on October 7, 2000 was informative and cohesive, and is bearing real fruit. I'll report first on the meeting itself, and then on developments. The all-day meeting, chaired and organized by Christine Lynn with help from Bonnie Oppenheimer and others, was held at The Washington School of Psychiatry. About sixty people attended, some flying in from California and Illinois, some coming by train from New York City. The day began with a great breakfast on site and concluded with a spectacular dinner; mainly, there was much food for thought. My husband, Stuart Silver, video taped the entire October 2000 meeting. ISPS-US is offering the set of three video tapes for $80 for non-members of ISPS, and $60 for members. To order, write to me, at 4966 Reedy Brook Lane, Columbia, MD 21044-1514, with a check payable to ISPS-US.

The program began with a fascinating report by Wayne Fenton on the history of the asylum, supported by slides and a video. I then talked on the history of psychoanalysis and psychosis in the U.S. Wayne and I were very pleased by how well our presentations complemented each other's. Without our planning it, there was no redundancy. Betty Oakes completed the morning's talks with a wonderful case presentation from her work at the Austen Riggs Center where she had served as Clinical Director. As at the Lodge symposia, the case presentation was the jewel in the crown of the day's offerings. There was a lively discussion, involving debate on medications and on diagnosis, as well as on specific psychodynamic issues in that successful treatment.

The afternoon's program was dedicated to the 1998 PORT study (The Schizophrenia Patient Outcomes Research Team Treatment Recommendations, headed by Anthony Lehman and Donald Steinwachs), which has been quoted in the NAMI (National Alliance for the Mentally Ill) trifold on treatment of schizophrena and in the Surgeon General's recent report on Mental Health. We are addressing its Recommendation 22 which states "Individual and group psychotherapies adhering to a psychodynamic model (defined as therapies that use interpretation of unconscious material and focus on transference and regression) should not be used in the treatment of persons with schizophrenia. Rationale. The scientific data on this issue are quite limited. However, there is no evidence in support of the superiority of psychoanalytic therapy to other forms of therapy, and there is a consensus that psychotherapy that promotes regression and psychotic transference can be harmful to persons with schizophrenia. This risk, combined with the high cost and lack of evidence of any benefit, argues strongly against the use of psychoanalytic therapy, even in combination with effective pharmacotherapy. (Review reference: Scott, J.E, and Dixon, L.B., 1995) Level of evidence: C

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"Recommendation based primarily on expert opinion, with minimal research-based evidence, but significant clinical experience.)

The afternoon's program began with a presentation by Anthony Lehman, senior author of the PORT Study. He gave us a sense of the background of the research effort, how the group had proceeded, and what its plans are. Their original protocol was to send the recommendations draft to 100 experts. None of them made objections to Recommendations 22 or 26, and so they were included. Dr. Lehman could not provide us with immediate information regarding the specific expertise of these readers. Were they researchers or clinicians, and if they were clinicians, how many patients with schizophrenia had they treated, and what was their specific training in this regard? He could not say. We then learned that his group plans a revision of the PORT Study recommendations.

Next, Bill Gottdiener presented his meta-analysis of all the statistical studies of the effectiveness of psychotherapy of schizophrenia. He had presented this material as a poster at the ISPS meeting in Stavanger, where he met with the ISPS-US contingent. We were very impressed by him and his work and he immediately became part of the gang. I had assumed that the Scott and Dixon study referred to the PORT Study was an earlier meta-analysis, and was surprised on finally reading it to see that it is a review of the literature, not a scientific study thereof. Next, Wilfried ver Eecke presented a splendid critique of the PORT Study assumptions and conclusions, bringing to bear his mastery of philosophy and of Lacanian theory as applied to psychosis. Unfortunately, we could not hold an in-depth debate, since Dr. Lehman had to leave promptly at 4:00. This conflict in schedule resulted because I had not kept him posted on a lengthening of the program from its original framework.

After Tony Lehman had left, Wayne Fenton said that his understanding was that the PORT revision was well under way, and that the results were to be released soon. This energized the group to maximal efficiency. Through e-mailing on the ISPS-US listserve and communicating privately, we considered launching a petition urging deletion of Recommendation 22. We decided to put the issue of the PORT revision on the ISPS executive board agenda. In its November 26, 2000 Thanksgiving weekend telephone conference call (some of the members having actually gathered for an all-day meeting in London) the group unanimously approved the establishment of a task force on the PORT Report.

Within a few weeks, Jan Olav Johannsen, the current ISPS President, had constituted the Task Force on the PORT Study Revision. Its members include John Gleeson (Australia), William Gottdiener (USA), Tor K. Larsen (Rogaland Psychiatric Hospital, Stavanger, Norway), Frank Margison (University of Manchester, Manchester, GB), Christof Mundt (Germany), John Read (University of Auckland, Auckland,New Zealand), and Colin A. Ross (The Colin A. Ross Institute for Psychological Trauma, Richardson, Texas, US). Tor K. Larsen is serving as its chair. Please contact him at tklarsen@online.no especially if you know of or are involved in studies of the effectiveness of psychotherapy for schizophrenia.

I then put Dr. Larsen in internet communication with Anthony Lehman. Lehman had written to us that the process of review of the PORT Report recommendations is just beginning, and the team is beginning to pull together a list of references. The ISPS Task Force is working on this simultaneously, and will be sharing its results with Lehman's group. Lehman welcomed this teamwork, and said he plans to include the Task Force among the reviewers of its drafts. We are very pleased to be included in this project, especially given the prominence the PORT Report receives in international mental health policy decisions. Our meeting was reported on in three articles by Aaron Levin in the November 17, 2000 issue of *Psychiatric News.*

After the ISPS-US meeting in Washington, our group reconvened at the 11th Annual IFPE (International Federation for Psychoanalytic Education) meeting in Chicago, November 3-5, 2000, whose theme was "Psychoanalysis and Psychosis." Many of us presented there as well. We held a board meeting there, and agreed to become an affiliate organization of the IFPE. I have sent them a brief description of ISPS-US for inclusion in their directory. We will soon send each member of IFPE a letter inviting them to join ISPS and to attend our October 6 meeting in Washington. Also at that meeting, the Chicago group, headed by David Garfield, and including some IFPE members who decided to join us, agreed to form an ISPS-US- Chicago Branch. They have since held their first meeting.

Thus, our Society continues to mature. First we were a gathering place for clinicians wishing to learn from each other. Next, through the internet, we continued our communications more regularly. We have a very active branch in New York City, and a developing branch in Washington, with new branches forming in San Francisco, Chicago, and Boston. Next, we have developed as a constituency group, advocating for particular kinds of treatment for patients suffering from psychosis. Now, with the ISPS Task Force on the PORT Report, we have become an organization actively involved in the writing of policy recommendations that affect worldwide governmental and other organizational decisions.

In May, at the New Orleans meeting of the American Academy of Psychoanalysis, we repeated our afternoon panel from our ISPS-US meeting, with Donald Steinwachs substituting for Anthony Lehman. This panel generated enthusiastic discussion and brought us some new members. It received prime billing on the front page of the June 2001 issue of *Clinical Psychiatry News* in an article by Sharon Worcester. Based on this article, the incoming editor of *The Journal of the American Academy of Psychoanalysis*, Douglas Ingram invited me to guest-edit the April 2003 issue of the journal, on the issues raised by the PORT Report. The ISPS Task Force is participating in this project enthusiastically. Also, mark your calendars for February 7 and 8, 2002, when the ISPS Task Force on the PORT Report will hold a seminar in Stavanger, Norway.

I hope that we will soon have 400 members. This will

allow us to actualize our next objective of publishing our own journal. Brian Koehler is exploring publication options, and David Garfield has volunteered to assist him in its editorship. Meanwhile, Barbara Cristy has graciously taken on the task of treasurer of ISPS-US. Julie Kipp will continue as Secretary. We have grown so much that it is not fair to task one person with these two time-consuming responsibilities. Please encourage people to visit the ISPS webpage, at www.isps.org, to get copies of past newsletters (both ISPS-US and ISPS) and information about joining us. To join ISPS, one joins through one's national organization. (For $40 a year, one is a member of both ISPS and ISPS-US.) Please help spread the word.

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From the Editor:

Psychoanalytic Contributions of Harold Searles, M.D. - Therapeutic Symbiosis and Patient as Therapist

Brian Koehler, PhD

Presented on October 2nd, 1999 at the Second Annual Conference of ISPS-US, Washington School of Psychiatry

In an autobiographical study, Freud (1925) stated, "Since the analysts have never relaxed their efforts to come to an understanding of the psychosis they have managed now in this phase and now in that, to get a glimpse beyond the wall." Harold Searles, I believe, is one of those psychoanalysts who has taken us beyond the wall. A wall created not only by the patient, but perhaps, as Martti Siirila believed, by our own collective self-estrangement. Searles has influenced at least two generations of psychoanalysts and psychotherapists. Gaetano Benedetti (1992), co-founder of ISPS in 1956, counted Searles as one of the three main influences on his own psychotherapeutic work with schizophrenic patients. The others were Marguerite Sechehaye and Heinz Kohut. My own personal list would include Searles, Gaetano Benedetti and Herbert Rosenfeld.

Searles, like Semrad, Garfield and others, understood schizophrenic experience to be a defense against various intense emotions. He saw the most basic problem in schizophrenia to be the patients having failed to develop a human identity. Searles (1979) believed that it was in the phase of therapy he termed therapeutic symbiosis, or state of emotional oneness between patient and analyst crucial for all patients, schizophrenic or otherwise, that a process of

> mutual rehumanization, as well as reindividuation, is enabled to occur through the therapeutic relationships having become sufficiently strong to enable both participants to let it come into play, in the ongoing exploration of the transference, subjectively nonhuman identity ingredients which heretofore had been split off from awareness and acted out in behavior.

Searles cautioned us not to view schizophrenia as predominently a deficiency disease. This perception may serve as a defense against the analyst's own sense of internal badness and need to reaffirm the good mother aspects of the analyst's identity by assuming an overly warm and giving approach to the patient, thereby asking the patient to rescue the analyst from her own "feared bad-self or bad-mother introjects." Searles believed that it was the analysis of the transference that is the central therapeutic activity in one's work with psychotic patients, as it is with neurotic patients. He strongly believed that our schizophrenic patients form inherently analyzable transference reactions, and that the limitations in therapy may lie in the therapist's capacity to, as the Kleinians like to say, "take the transference." Searles believed that it was important for the analyst to not only endure, but even come to enjoy the transference positions which the schizophrenic patient places her into, e.g., the schizoid father, or paranoid, overly intrusive mother. Yet it is in his cogent observations of the countertransference that perhaps Searles is best known and for which he is most appreciated. In an interview with M. Stanton, published in 1992 in Free Associations, Searles revealed that he had a persistent fear of becoming psychotic which resolved with his discovery that his internal contents could be mined for invaluable insights into the patient's inner world and put to therapeutic use. Searles stated, "... it is the therapist's own dawning recognition of his countertransference ... that provides the best handle for his effecting a change in the therapeutic relationship."

For me, Searles' concept of the patient as therapist to her analyst is one of his most deeply creative contributions and is certainly reflective of his ability to "take the transference" in all of its

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From the Editor, continued

murderous and rageful aspects and to follow it through to the deep core of hurt, unreceived and unacknowledged human lovingness underlying all the colorful symptomatology of schizophrenic experience. This kind of observation could only emerge after long-term intensive relatedness with the patient. A concept and observation like this would make no sense to clinicians who only have fleeting contact with patients in this time of brief treatment and timely hurried discharges. Searles noted that often schizophrenic patients fear emotional closeness because it may mean the destruction of the other and therefore of the self. He saw these fears as reflective of "truly formidable components of sadism and murderous hatred" but more so as "an unconscious need for experiences of a therapeutically symbiotic nature – a kind of relatedness with the analyst which only gradually, bit by hard-won bit, becomes free from intensely threatening components to both participants in the work, as it gradually becomes evident that such symbiotic relatedness does not involve the actual destruction, mentally or physically, of either or both of them."

Searles believed that innate among human beings most powerful strivings toward their fellow human beings is an "essentially psychotherapeutic striving." He conjectured "that the schizophrenic patient is ill because, and to the degree that, his own psychotherapeutic strivings have been subjected to such vicissitudes that they have been rendered inordinately intense, frustrated of fulfillment or even acknowledgment and admixed therefore with underlying intense components of hate, envy, and competitiveness ... In transference terms, the patient's illness is expressive of his 'unconscious attempt to cure the doctor.'" Searles felt that the more ill the patient is, the greater the need for the analyst to acknowledge the patient as having become a therapist to "his officially designated therapist." From this conceptualization flows a profoundly altered approach and understanding of the curative process in the psychoanalysis of psychosis. The patient has basically postponed, as it were, her own individuation in the service of functioning symbiotically as a therapist to one or another family member perhaps out of separation guilt and authentic altruistic motives.

In sharp contrast to those analysts who subscribe to the concept of the need-fear dilemma in schizophrenia, which understands the patient to be suffering from a crippling ego defect and as needing supplies from without, and as being oriented toward receiving rather than giving to the environment, Searles stated:

> " . . . the basic psychodynamics of such schizophrenic phenomena warrant, in my clinical experience, an utterly contrasting emphasis as being the truer one, and this emphasis is crucial for any successful psychotherapy of the schizophrenic person. His impairment in whole ego functioning, his inability to function as a whole individual, is due most fundamentally to a genuinely selfless devotion to a mother, or other parent figure, the maintenance of whose ego functioning required that the child not become individuated from her (or him)."

Yrvö Alanen (1997) has more recently stated a similar position based on his extensive family research and psychotherapeutic experience with schizophrenic patients in Finland. He saw the core tragedy experienced by many parents of schizophrenic children as their tendency to live too much through their children, to have an excessive need to utilize their children as self objects into which to projectively identify their own frustrated needs for empathic love and then vicariously experience gratification of such deep unmet needs from their own childhoods.

Searles regarded the crucial issue in the intensive psychotherapy of schizophrenic persons to be the following:

> "In this regard we personify in transference terms the parent whose relationship with him over the preceding years has been fixated at a symbiotic level, but as I have emphasized repeatedly, it is not only transference. The therapist comes to feel that he really is, to a significant degree, at one with the patient, and to experience it as becoming a real issue whether he, the therapist, can bear the loss to his own ego functioning of the individuation toward which the therapeutic endeavor is directed. Thus, in retrospect, the schizophrenic patient's ego defect, toward which it is so easy to feel a kind of pitying condescension, becomes translated as having a frightening degree of personal importance to the therapist's very self (with the patient being equivalent to the therapist's heart or mind, for example). The more conscious the therapist becomes, and remains of these processes, the less likely is any acted-out folie a deux to occur."

Searles position is also very similar to that of another revered analyst of schizophrenic persons, Gaetano Benedetti. Benedetti (1987) believed that we not only need to communicate to the patient the "psychodynamic linings" of his illness, but more importantly, the "meaning his existence holds for our own". Benedetti believed that "in this art of communication, which is reflected by him to us, we too are changed, and it is this, our very ability to let ourselves be transformed, deepened and enriched, which has an effect on him." Benedetti stated: "Perhaps it is really our very gain from the contact with the patient that constitutes a mainspring of his improvement, insofar as he thus undergoes the fundamental experience of giving as well as receiving."

I would like to conclude with some words from the 18th century Japanese poet, Kobayashi Yataro, born in 1763 and known to the literary world as Issa.

The theme is mourning the loss of a cherished home and the seeds of transformation contained therein – much like our loss of the approach to psychosis taken by such analysts as Searles and most importantly, the hope and creative generativity such an organization as ISPS represents for us.

These words are from Issa's "The Spring of My Life"

No matter how hard
I can't stop thinking
of my old village.

Memory returns
to those ancient misty trails
around my village –

But neither flowers nor love
bloom there – only my sadness

So very, gently
it won't even disturb
the butterfly,
this soft spring wind wanders
over deep fields of new wheat.

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From the Secretary

I am so delighted to be turning the treasurer duties over to Barbara Cristy. It has been a pleasure working with Barbara on the transfer of the work. I'm especially appreciating her organizational skills and easy-going style.

Having given up the job of treasurer, I return to duties as layout person and assistant editor for the Newsletter. We weren't completely thrilled with the professional layout job we had done last time, and so I give it another shot in this issue. We would still love to include photos, which *can* be done in this xeroxed format, albeit with some loss of clarity. If anyone is knowledgeable in scanning or converting digital photos (we have a scanner, partially donated by Allen Kirk some time ago), and would be willing to instruct me by phone or e-mail, I would be grateful.

I'd like to take this opportunity to encourage anyone who has not yet checked out our listserve to do so. It's not one of those listserves which max out your mailbox if you don't check on it every day, and the quality of the postings is impressive. Also, I'm very much looking forward to seeing everyone at the October meeting of ISPS-US in Washington DC.

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From the Treasurer

Now that I am the new treasurer of ISPS-US, I can see what a hefty job it is. And to think Julie Kipp was both treasurer and secretary! I am impressed. I want to use this opportunity to thank Julie for all she has done. Because of her efforts and all the efforts of those who havevolunteered, our chapter has grown sufficiently to warrant applying tothe IRS for non-profit status. Previously, we could claim that status without formally applying because our income was so small. Now that Julie Wolter (jwolter@safeplace.net) is in charge of Membership Recruitment, we can look forward to even greater growth, strength and diversity.

Recently, a group of ISPS-US-DC (Washington branch) members got together to stuff envelopes for a large mailing. (To those of you who sent in your 2001 dues before this latest mailing, I apologize for the duplication and confusion.) That tedious job turned out to be easy and fun as we kibbitzed while stuffing envelopes, licking stamps, and ating Chinese carry-out. I remembered the last time I did anything like this. It was during the summer of 1960. Al Haber, Mimi Abramovitz (nee Gruber), another friend of ours and I (nee Englander) spent that summer starting the Ann Arbor chapter of SDS (Students for aDemocratic Society). I had no idea at that time of the significance ofwhat we were doing. Was it because I was too young? Or is that something one understands only in retrospect? The impact we were to have on the civil rights movement and the anti Viet Nam War movement was staggering. I was participating in launching an incredibly important time in the history of the United States. I wonder if I am now participating in a major mental health movement with implicationsfar beyond my imaginings. Its fun to think that I am.

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What is tolerable? Use of the potential space in the treatment of psychosis

Warren Schwartz, PsyD

Psychotherapy is most effective when both therapist and patient are able to play (in the 'Winnicottian' sense) (Winnicott, 1971). For the patient, this means the freedom to associate and come to interpret his experience. For the therapist, play is, in part, the act of freely using his experience of the patient to form and deliver interpretations that deepen the patient's experience of himself and other. Thus, the expansion of a patient's awareness takes place in a potential space, an overlapping area of play between the patient and therapist (Winnicott, 1971). The development of this "verbal squiggle game" (Ogden, 1997) requires patience and sensitivity, as patients need to experience holding in a relationship before they can risk unmasking what lurks beneath their manifest communications (Winnicott, 1971). This patience and sensitivity may be especially important in work with psychotic patients, who often have only a thin veneer of protection from a core of terror.

Ogden delineates "psychopathologies of potential space", which are, in short, intrapsychic conditions that disallow play. One such "psychopathology of potential space" is manifest in patients who are unable to "…experience a metaphor as a metaphor" (Ogden, 1997, p. 725). The sources of many patients' misery lies in their inability to clearly express their discontent through language or through some other creative, metaphorical, and consensually meaningful way. Instead, their dissatisfaction with the world becomes repeatedly represented unconsciously and symptomologically. These patients need to reach a place where they are able to engage in the metaphor game if they are to understand themselves. However, play in the verbal mode cannot be a meaningful part of treatment until the patient's affect is understood and 'contained' in the non-verbal realm (Searles, 1962). Only when the patient is ready should the therapist opportunistically elaborate on her experiences in the form of "deepening interpretations."

Patients have symptoms partly because they have no other way of expressing to themselves and others the sources of their unhappiness and their experiences of unhappiness. They need their symptoms until they can find a healthier (i.e., more playful, creative) way of expressing themselves. Stealing a patient's symptoms does not help that patient come to trust anyone because the transitional process in which holding normally emerges is bypassed. The demand for symptom abatement instills in the patient a need to comply with the aggressor and become "healthy" as the therapist defines health. Despite the danger inherent to this type of practice, therapy all too often consists of taking away a patient's symptoms and replacing their mode of communication with something alien to them such as a technique or so-called "coping strategy." Therapists practice "defensive psychotherapy" (Bollas & Sundleson, 1995) when they are afraid of play or unconscious exploration, and defend against this fear by muting patients with medication and other active management strategies.

Even if our goal is to eventually relieve the patient of his painful symptoms and help him to reach a state where he can understand himself and communicate creatively, it is important that we let a treatment take its course. In other words, it is important to tolerate symptoms and allow them to disappear at their own pace instead of stomping them out. Central to this process is faith that what we are doing with the patient will be effective.

For therapists, a tolerance of terror and madness within themselves is as important (Giovacchini, 2000) as tolerating what is presented externally (from the patient). Reverie is, however, often quickly dismissed by many therapists because of the apparent meaninglessness it represents and because of the terror it can contain. Reverie is elusive-- it is "…intimately connected with unconscious experience" (Ogden, 1997, p. 721). These thoughts and feelings do not occur on a fully conscious level, and thus, access to them proves quite difficult unless one pays close attention to his internal processes.

Many times these resistances to self-inspection are strengthened by training experiences that further discourage personal, subjective reactions to the patient. Trainees are often taught to objectively focus on the patients' process and progress in treatment. Since therapy requires an opening of potential space, and this entails an allowance for *overlapping* areas of play, dismissal of the therapist's subjective experience of the patient means a foreclosure of potential space. The deepening of the relationship and the potential for a therapeutic outcome thus necessarily suffers under these conditions. In these unfortunate cases, the supervisory situation does not serve as an adequate holding environment (Jacobs, David, & Meyer, 1995) in that it does not allow for play. Instead, this supervisory situation restricts trainees from exploring the symbolic, derivative material that is representing their unconscious processes. These conditions frustrate a therapist's attempt to open himself up to his day-dreams [which may already naturally induce feelings of shame, guilt (Freud, 1907)) and terror]. In such circumstances, the trainee misses important countertransference information and the treatment and learning process suffers.

Instead of allowing playful processes to occur (in verbal and nonverbal realms), many institutions and practitioners shrink from these processes in fear. This becomes manifest in shorter appointments, shorter lengths of treatment, more active strategies (to extinguish symptoms), and a limited provision of comfortable therapy space (in the physical sense). Restrictions such as these reinforce the notion of "mental illness", the idea that patients have a diagnosis that should be *managed* only with medication and active strategies. Instead of working through the meanings of their difficulties, patients become resigned to technique and other forms of systematic control. They accept their label of "mentally ill" and

define themselves as part of this culture rather than recognizing the uniqueness of their experiences and how these can become integrated into a new reality. When used alone, so-called "ego-building" techniques only reinforce false selves in patients that have been built up by the aggressive and defensive institutions in which these patients have been entrenched.

Many therapists argue that psychodynamic therapies are inappropriate for psychotic patients because these patients cannot tolerate self-exploration, even in contained settings. The truth is, sometimes it is therapists who cannot tolerate a deep empathic connection with their patients. The denial of the effectiveness of psychoanalytically oriented psychotherapy is often used as a rationalization for not providing depth treatment, and this leaves patients in sterile, unimaginative, detached relationships with their therapists. These are often the same types of relationships that represent their dysfunction

The choice to embrace the irrational contents of one's mind entails standing out from the herd and facing the interpersonally generated anxiety inherent to questioning what is considered to be the correct way of doing things. Embracing the irrational also requires facing a more intrapersonal or individual type of anxiety. That is, the anxiety associated with not knowing (Casement, 1991) and the anxiety associated with terror. Again, this requires faith that what we are doing will benefit the patient in the long run.

Following and mastering a technique may help a therapist gain approval from her colleagues and may provide her with a sense of security in knowing. However, relying on technique as a defense against the anxiety associated with the powerful derivatives of a 'psychotic relationship' can cost the therapist her creative capacities and can leave the therapist with little personal meaning and investment in what she is doing. Most importantly, the resistance to subjectivity and the suppression of playful experience in both patient and therapist, robs patients of the possibility of developing genuine relationships with their therapists and precludes the possibility of a creative, transitional process in the treatment.

The potential space in therapy (that space where the patient and therapist creatively play) can exist only if the therapist is able to overcome her resistances to acting creatively herself. Play always involves a respect for what is not known (or what may never be known). It requires us to take a humble stance and to allow the patient to teach us bit by bit what we are creating with him and what he is and isn't ready for. Only if we allow this transition to occur as directed by the patient can we navigate the transition between his illness and health.

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Notes from the Chicago Circle:
An attempt to organize a treatment program for psychotics

Charles Turk, MD

Five years ago several of us, engaged in the daunting task of studying Lacan's concepts, availed ourselves of the opportunity to attend weekly summer seminars in Quebec City conducted by Willy Apollon, Danielle Bergeron and Lucie Cantin. The three analysts, trained by Lacan, founded GIFRIC (an acronym for: The Interdisciplinary Freudian Group for Research into Clinical and Cultural Intervention). Their teaching is conducted through GIFRIC's educational arm, EFQ (Ecole Freudienne du Quebec). As the seminars have evolved the three have urged attendees from various parts of the United States to organize as "Circles" of EFQ. At this time such groups exist here in Chicago and in California (San Francisco), Boston, Atlanta, New York, and most recently Puerto Rico.

Each circle periodically hosts a "clinical day" where Willy, Danielle and Lucie respond to clinical cases and topical papers presented by members of the circle. These informal - but quite instructive - interchanges we find both individually stimulating and supportive of our Circles' group effort. While we strive for consistent attendance in our small groups, we welcome new members who will commit themselves to immersing themselves in study. Our most recent "clinical day" immediately preceded last November's IFPE meeting in Chicago. Three members of our "study group on psychosis," Greg Rosen, David Seiberling and I, presented a clinical panel at the IFPE meeting entitled "Opening up a space for speech for the psychotic."

Our core group, Lucia Villela-Kracke, Waud Kracke (who also presented papers at the IFPE conference) and I, meet weekly both to discuss various texts - those of Freud and Lacan as well as our notes from the summer seminars. We also use these sources to plan for the content and direction of a "work group," with a more theoretical orientation.

Our other study group on psychosis is composed of clinicians dedicated to the psychotherapy of psychosis. We are engaged in developing a therapeutic milieu as a result of contacts we have had with a day treatment program. We approached an existing psychosocial rehabilitation program with a proposal based on a particular treatment concept we developed.

This concept was based on a treatment program for psychotic young adults that GIFRIC developed. The sequence of texts we draw upon: Freud - Lacan - GIFRIC reflect a progression of concepts regarding the treatment of psychosis. Where Freud was pessimistic about treatment because he felt that psychotics could not form transferences, Lacan was also pessimistic because he felt that any transference formed would inevitably gravitate toward erotomania. The Canadians' approach is based upon a long-considered and careful study of their treatment of psychotics. It focuses on creating - perhaps for the first time - a subjective position for the psychotic, solely through the medium of hearing out his speech. Here the psychotic's transference is a response to the *desire* of the analyst, whose task is to grapple with the welter of all his desires - and make paramount his single-minded desire to know.

This treatment program, known as "388," derives its name from the street address of a house in a residential area of Quebec City, in which it is located. It offers an alternative to traditional treatments that generally regard the psychotic as "objects" of observation and care, by involving them in a milieu which guides each of them toward an analysis. When the psychotic experiences a crisis, 388 offers him or her an alternative to hospitalization - a place to stay and be attended to around the clock.

When 388 was founded, skeptics expressed the conventional wisdom supported by our cultural ideology in declaring that psychotics could not tolerate the proposed psychoanalytic form of treatment - and would only be made worse by it. One wall of the residence's parlor is formed by a beautiful stained glass partition. That it has remained intact over the twenty years of 388's existence, testifies to the character of the milieu that dissolves aggression by a detailed insistence upon the psychotic's expressing himself through speech - as well as through non-verbal creative endeavors.

At 388 crises are managed by assuring that the psychotic is never alone; he is attended by someone dedicated to his well being and to assisting him to make sense out of the chaos he experiences. Lending the psychotic "plenty of ear", fosters a space for the psychotic's speech to become the avenue that he can traverse to exit from his illness.

This refers to the Canadians' concept of the "second logical phase" in the treatment of psychotics - to establish a subjective position for the psychotic, by hearing out his delusion while constraining its effects. The first phase consists in the already existing work that the psychotic brings to treatment, namely his engagement in a delusional effort to repair a defect in "his" world. If the psychotic becomes engaged in the treatment, delusional certainty begins to be replaced by the restraint of insight - a new knowledge referred to as *savoir*. The psychotic then enters the "third logical phase" - where he addresses his illness, this often takes the form of confronting a delusional object. The "fourth logical phase," generally negotiated in the context of a firmly established analysis - deals with a reproduction of the illness precipitated by the psychotic's attempts to mend his ruptured "social link" as he engages in some personally productive activity in the community.

As implied in the situation of the fourth phase, each phase is characterized by a crisis particular to it. In the first phase the psychotic presents himself for treatment, not - as we might

think - to "get better," but rather to get assistance in shoring up the place where his delusional work is failing. The second phase leads to a "crisis of engagement" where the psychotic - perhaps for the first time - is immersed in his illness in the company of others who are dedicated to his well-being. When further movement evolves into the third "crisis of confronting the illness," the psychotic must bear the awareness of being ill - and for some it is too much to bear and they choose to avoid it. But if successfully negotiated, the psychotic has now attained a new position that enables him to return to a potentially satisfying role in the community. But this confronts him with the "fourth logical crisis," to re-enter a world that had been lost to him, and which now may be inhospitable.

The theoretical scaffolding upon which we based our own proposal is delineated in the Canadian's recounting of their experience at 388, entitled "Traiter la psychose." As this text had not been translated into English, we have taken up the task of translation that is now nearly 2/3 accomplished. "Traiter la psychose" has provided us with concepts for study and to use in developing our proposal.

In brief, our proposal to the director of the psychosocial rehabilitation program would introduce a "listening component" into the presently existing program. This would address a problem the director delineated, namely that several of their clients retrogressed after a promising improvement or seem "stuck" in delusions that rob them of the good function they enjoyed before breaking down. The new "listening component" would be articulated with programmatic elements already in place. They would function to constrain or limit the delusional discourse, while other time would be opened up to hear out and work with the delusion. The goal would be to transform "autistic" delusional elements into activities with a social value in order to assist the psychotic in re-entering "the world" on the basis of productive and satisfying activity. This is predicated upon his first having repaired his ruptured "social link" - the sum of the internal representations that form a foundation for relatedness with others.

We know that developing our proposal is an arduous one, as its heart will be the goodwill and motivation of their staff, to work with us to consider a different way of approaching the psychotic - through careful listening - a task that we know is time consuming and difficult. But we are heartened by the director's comment on reading our material. "This is amazing," he exclaimed to me. We hope that his response can be transmitted to his staff so that we can work together to support this novel way of working with the psychotic individual. Time will tell if this comes to fruition, and meanwhile - just as in our approach to the psychotic individual - we simply have to bide our time and sustain our efforts.

To conclude, at the recent IFPE meeting we had the opportunity to meet David Garfield who is interested in developing a Chicago Chapter of ISPS-US. An initial meeting of interested clinicians is planned for late January, where we hope to form an organization among those of us who spend time with our patients in those quiet places our work with them requires. Given the uncaring times we find ourselves immersed in, our work has taken on the characteristic of a "not-so-splendid" isolation - an isolation that our forming our own community might mitigate.

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News from the Chicago Chapter of ISPS-US

Julie Wolter, MA

The first meeting of the Chicago chapter of ISPS-US was held January 27, 2001 at The Institute for Psychoanalysis, 122 S. Michigan Avenue, 13th floor. The meeting began with an informal presentation by Charles Turk, MD, about the 338 Griffique model of acute residential treatment for psychosis from a Lacanian perspective and the remainder of the meeting was dedicated to ideas regarding the development of the chapter as well as future meetings. We envision the chapter as a local network of mental health professionals who work with psychosis and will meet on a regular basis for support and for discussion of cases and theoretical application.

The second meeting of the Chicago chapter of ISPS-US is scheduled for Saturday, March 10, 2001. The first meeting was much larger than anyone had anticipated with some 25-30 people attending. Analysts, therapists and trainees from private practice, Reed State Mental Hospital (The Old Chicago State Hospital), VA hospitals, community mental health centers, and a variety of institutes, medical schools and graduate schools all showed up. The variety of experience level was impressive from people just starting out to those who had been working with psychotic patients for over 45 years. Needless to say, it was a stimulating meeting, and the enthusiasm for outreach into the community was inspiring. The next meeting will continue discussing how ISPS-Chicago can meet the needs of the chapter members as well as become an integral part of the mental health agencies that serve people needing treatment for schizophrenia or psychosis. The Chicago chapter is committed to service, education/supervision and scholarship. If you would like more information, contact David Garfield, MD at 847-578-8705 or DASG@aol.com or Julie Wolter, MA at (847) 733-9228 or jwolter@safeplace.net. If you plan on attending the next meeting, please call Julie Wolter at the above phone number/e-mail address.

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EDITOR'S NOTE: Since this report, there have been several more Chicago chapter meetings. Minutes can be found on the ISPS-US ListServe, along with minutes of chapter meetings in New York, Washington, and San Francisco.

Childhood Schizophrenia: Bender's Neurobiological Theory

James B. McCarthy, Ph.D.

At present, childhood schizophrenia is described in the scientific literature as being essentially similar to schizophrenia in adulthood. Current research findings generally point to a biologically based continuity between signs of schizophrenia in childhood and the symptoms displayed by individuals with adult onset schizophrenia. Within the last ten years, studies have outlined similarities in cognitive deficits and perceptual immaturities as well as positive and negative symptoms between childhood schizophrenia and adult schizophrenia. Contemporary models of psychiatric practice likewise emphasize the genetic predisposition to psychotic symptoms and thought disorder in children who develop schizophrenia. With the removal of childhood schizophrenia from the DSM classification system and the widespread acceptance of DSM nosology, there has been less debate about the appropriateness of adult diagnostic criteria for children with severe psychopathgology. There has also been very little consensus about which characteristics of children at risk for schizophrenia may be predictive of a persistent course of schizophrenia later in the individual's life.

As early as the 1930's, Lauretta Bender's pioneering research studies with psychotic children sought to discern whether schizophrenia may be expressed differently during childhood and adulthood. Bender's research at New York's Bellevue and Creedmoor State Hospitals involved longitudinal assessments of several hundred children and adolescents with schizophrenia. Her long term follow - up studies served as the foundation for her theory of the heterogeneity of schizophrenia. This theory integrated the importance of psychological factors in the development and treatment of schizophrenia in its many manifestations with its primary etiology in abnormal neural development.

Bender's far reaching, neurobiological theory of etiology anticipated the present view of schizophrenia as a chronic, neurodevelopmental disorder that varies in symptom frequency and duration with typical emergence in late adolescence or early adulthood. In anticipation of current research in neurobiology and neuro-psychology, from the 1930's through the 1960's Bender questioned whether the emergence of schizophrenia at different ages might have a divergent impact on developmental stages. Bender's emphasis on prospective assessments anticipated the methodology of present day high risk research studies of children or siblings of adults with schizophrenia and other potentially vulnerable youngsters.

Bender (1954, 1960, 1972) believed that schizophrenic children inherit a "neurointegrative deficit" that correlates with an unevenness and gaps in their psychological and neurological maturation. She suggested that these developmental lags are universal in children with a predisposition to schizophrenia. Not all of these identified children were thought to develop full symptoms of schizophrenia, and no one symptom was considered to be pathognomonic. Bender summarized her work in a 1969 review that referred to both genetic influences on neurological maturation and the failure of psychological defenses in childhood schizophrenia.

"The concept of childhood schizophrenia which I have developed is a psychobiologic entity determined by an inherited predisposition and precipitated by an early physiologic or organic crisis and a failure in adequate defense mechanisms, persisting for the lifetime of the individual, but exhibiting different clinical or behavioral psychiatric features at different epochs in the individual's development and in relationship to compensating defenses. I see the autistic (Kanner, 1949) and symbiotic (Mahler, 1968) features in infancy and early childhood, the psychoses of mid and late childhood, remission in puberty, the pseudoneurotic and pseudopsychopathic features of adolescence and the wide range of regressive and psychotic conditions of the adult" (Bender, 1969, p. 165-166).

In her discussion of inadequate defense mechanisms, Bender highlighted her own efforts to integrate a developmental, biological perspective with psychoanalytic views of ego decompensation in childhood psychosis. These efforts reflected the influence on her thinking of the writings of Paul Schilder and early ego psychologists who emphasized the importance of anxiety in childhood psychoses. Bender spoke of an underlying core anxiety that compounded adverse intrauterine or perinatal events. She saw the resulting childhood schizophrenia as a disorder of the complete organism and an early manifestation of the schizophrenia that appears in adolescents and adults. The child's deterioration in schizophrenic illness involved a total disorganization in psychological and physiological functions.

Bender's attempt to classify autism as a subtype of childhood schizophrenia exemplified the 1940's and 1950's perspective that infantile autism and childhood schizophrenia were not fully distinct disorders. She argued that the earliest emergence of schizophrenic symptoms took the form of pseudoautistic or pseudoretarded phenomena among very young children, while her references to pseudoneurotic and pseudopsychopathic schizophrenia during later developmental stages also alluded to thinking that was prevalent in the DSM I and DSM II. More importantly, Bender's diagnostic conceptualizations pointed to the need to follow children prospectively in order to insure the accuracy of diagnosis and the adequacy of treatment. Based on the comprehensiveness of her clinical assessments and the all inclusive nature of the schizophrenic child's deficits, in her approach individual psychotherapy, family therapy, occupational and recreation therapy all played significant treatment roles in addition to medication. Many of her early experimental efforts at treatment interventions predated the availability of antipsy-

chotic medications in the United States.

In a (1970) study on the life course of schizophrenic children, Bender included follow up and prognostic data that inferred far from universal outcomes. Bender's work, like that of Leo Kanner, Barbara Fish and other investigators of childhood psychoses, was later criticized for its lack of rigid diagnostic criteria and sophisticated methodology. Contemporary researchers' demarcation of deficits in sustained attention, memory, information processing and poor social functioning among children with well-defined features of schizophrenia perpetuates Bender's research tradition of comprehensiveness in assessment. One of Bender's most long lasting contributions may have been her plea for multidimensional treatment interventions that foster schizophrenic children's return to an appropriate developmental path and enhanced social functioning in the community.

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Letters to the Editor

From Al Honig, DO

At the meeting in Stavanger, you and I, while discussing many of the issues of the day, casually interchanged views about research. You asked that I write down my thoughts, especially about severe mental disorders and chronic schizophrenia.

You may use the following remarks in the ISPS - US newsletter and invite further discussion from other interested members:

Research with severe and chronic mental illness has been concentrated mostly in outcome studies. Different settings used their own methods in their therapies with their patient population. There have also been published studies in expressed emotion and adopted twins. All have provided valuable information.

All this research is quantitative, and is based on measured evidence. However, it is my contention that research in the field of serious and chronic mental illness is still in the primitive stages. This is certainly true in the broad range of psychotherapy.

In all other chronic diseases of the human organism, where there is no known cure, treatment tends to be holistic and non specific. For example, in the treatment of tuberculosis before the advent of antibiotics, therapy consisted of rest, fresh air, wholesome diet, exercise, and the elimination of known toxins, such as tobacco.

Radiology is a relatively new science in medicine. In its beginnings, the reading of x-ray was an art form. Gifted practitioners were able to see pathology where less creative physicians could not.

Trained originally in osteopathic medicine, I am very familiar with chronic ailments. Chronic degenerative diseases cannot be ascribed to a single eradicable cause. Their etiologies are complex-the products of whole constellations of factors of the ways and circumstances in which one lives and has lived, both subjective and objective (genetic, developmental, psychologic, perceptual, sociocultural, structural, nutritional, and environmental). The only hope for enduringly effective treatment and for prevention, and lowered probability is to move patients, and the not yet sick to more favorable life patterns.

The whole person approach is favored over reductionism (reducing a person to it's parts, studying these parts and their interactions, and finding the cause of the dysfunction. Finally, a chemical or physical agent is administered to set the parts right). (see Korr I, Medical Education: The Resistance to Change. Aug. 1988 *Jrn. of the AOA*, Vol. 88 #8, Chicago.)

The reductionistic approach dominates medical research and has been enormously productive. It is the source of many of our greatest medical discoveries, but is it enough to understand the human psyche?

Mental disorders (including the schizophrenias) are chronic illnesses. We do not know enough about these illnesses to say that they are medical diseases, and therefore assign them to a reductionistic treatment.

Qualitative research should be a main focus. Theoretical formulations and case histories must be published. Emphasis should be toward exploration and the experiential. Psychotherapy is still more art than science and should embody the literary techniques of narrative, dialogue, simile and metaphor, characterization, and point of view.

I am sending a copy of *The Awakening Nightmare* (Honig AM, American Faculty Press, Rockaway NJ 1972) to you under separate cover. Julie might enjoy the section on regression.

fraternally,
Al

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Letters to the Editor are continued on page 17

Sullivan The Clinician

Kenneth L. Chatelaine, PhD

[EDITOR'S NOTE: This is the second of a three-part series]

THE SPECIAL WARD – IMPLEMENTING THE TREATMENT MILIEU

In order to implement the technique of therapy that he labeled "treatment milieu," Sullivan established and operated a special ward for schizophrenic men during his final twelve months at the Sheppard Pratt Hospital in Towson. Housed in what was then known as the Reception Building, this ward functioned as a patient-receiving service designed according to his own specifications as a clinical social structure. Management of the area was totally Sullivan's responsibility, in a unit remarkably divorced from the various hierarchical structures usually governing hospital administration. Always controversial, in 1929 Sullivan was almost fired from his professional position by the hospital's Board of Trustees for what their perceptions were of his work on the ward.

Entirely removed from the supervision of the Nursing Service, no woman except for a female housekeeper was ever allowed access to the area. All attendants were specifically chosen and intensively trained by Sullivan himself, and although classified as sub-professional, came to operate in a truly professional manner. The team developed a high esprit de corps; even holding their own informal staff conferences either at a local bar or in the house established by their mentor near the hospital grounds. Sullivan's theory was that these attendants who were so successful with schizophrenic patients were potentially schizophrenic themselves, a concept aligned with Sullivan's own testimony that some of his own skill likewise derived from his own early personal encounters with schizophrenic processes.

Sullivan's reasons for eliminating the registered nurse from his ward stemmed from certain important theoretical considerations. *He was convinced that the schizophrenic patient had in his formative years suffered humiliation within his family structure, as a result of which he was now enduring an acute sense of low self-esteem.* To expect such an individual to find a cure within an institution riddled with outworn codes of hierarchical values was to Sullivan nonsensical and self-defeating. The presence of the registered nurse on his all-male ward would also have represented a prototype of the high-status female in an inferior male society. Thinking of the power struggle conducted in the home where the mother pays deference to the authority of the father, but in fact governs the household, Sullivan perceived the hospital as a place where the nurse often pays deference to the physician yet in fact rules the ward. There was no place for interaction such as this on Sullivan's unit. His initial and foremost concern was for the already damaged self-esteem of his patients.

Sullivan's theory was that a patient's treatment would begin with removal from the situation causing his difficulty. *His intent was to encourage the schizophrenic to renew efforts at adjusting to others*, and felt that this could be accomplished only within a ward that was homogeneous in sex, age, and diagnosis. Since he felt strongly that the first twenty-four hours of hospitalization are the most critical for the patient, he could not in good conscience subject them to an institution devoid of "protection" and privacy where the individual's feelings of utter humiliation and degradation would only be reinforced. He instead encouraged his special attendants to spend a great deal of time with the new patients, and to give them as much reassurance as possible. A protective wall was constructed at Sullivan's request, which served to shield his patients from the view of any outsiders entering the building. Unless admitted to the other side, no one could see any interactions taking place on the ward. To Sullivan, the routine daily life of the individual was more crucial to his clinical progress than any single hour spent with a therapist.

Sullivan was aware, however, that the role of the physician is of critical importance in treatment. Feeling that the small amount of time shared between doctor and patient was crucial, he utilized the crude recording devices available at that time to assure that all interactions taking place could be analyzed and investigated. Microphones hidden on his desk, in the ceilings and in the bathroom were controlled with switches concealed within his desk drawers, while a secretary stationed one floor below accurately recorded all that transpired.

III. SULLIVAN, THE CLINICIAN IN THE OFFICE - THE PSYCHIATRIC INTERVIEW

Fundamental to Sullivan's theory was the notion that the psychiatrist or therapist is inescapably involved with all that is happening during the course of the session. He also felt, as expressed in his book *Clinical Studies in Psychiatry* that no one has_grave difficulties in living if he has a very good grasp on what is happening to him. Because of this, Sullivan's emphasis in therapy was not upon uncovering and bringing to the surface unconscious content, nor was it upon the encouragement of a dependent clinical relationship. *It was clear communication that he sought.* To Sullivan, the mission of the therapist lies in assisting the patient to grasp and articulate his experience. Returning to his concept that it is the interaction of people with other people, which causes anxiety, he emphasized the impact of a significant other (the therapist) upon the development of the individual (the patient) by utilizing a therapeutic tool he called *"participant observation."* By studying his own role as psychiatrist, he developed the theory of the analyst as one who not only observes, but also participates.

Since, for Sullivan, all personality handicaps are manifestations of anxiety produced by an individual's significant others, it followed that anxiety could only be revealed and understood in the presence of a significant other as portrayed by the therapist. *The kind of person that the therapist is, what he does, what he says, and how and when he says, it, are all things that relate di-*

rectly to a patient's success in treatment. While both patient and therapist are strongly motivated to meet, they are both equally driven by anxiety to withdraw from each other. An interplay of movements—multiple variations of advance and retreat—characterize the clinical interview. Recognition of these movements and an exploration of their origins is the goal of the time spent together in the interview, a process which, Sullivan hoped, would lead to an understanding of their significance within the existing situation.

Sullivan observed in working with schizophrenic patients that language is often used more as a defense than as a means of communication. The individual who experiences a great deal of anxiety in contacts with others can keep them at a distance, either by withdrawing physically or by speaking in a way that makes the listeners withdraw. This is not a conscious or planned action on the part of the patient, but is a complicated response to anxiety resulting in a successful avoidance of people. Sullivan termed this type of defensive pattern (along with others, such as selective inattention, dissociation, paranoia, and obsessionalism) a dynamism of difficulty. To him, such reactions were an indication that mental patients are no different from other people, but are, in fact, striking examples of common human experience.

Sullivan felt that few people, and certainly no patients, come into the presence of others without considerable caution and some expectation of rebuff. For him the understanding of the resulting communication blocks established between individuals is necessary to the comprehension of humanity's common underlying anxiety and anticipation of hurt, and is a major goal of the treatment interview. The clinical interview was, to him, a miniature of human communicative processes, containing the essential qualities of all interpersonal relationships. During it the person being observed could be comprehended only in terms of his relationship to others influencing him, and in terms of the behavior of the observer (the therapist) who is a part of that field of influence. According to Sullivan there could be no situation in which the interviewer (therapist) exists as a "neutral" figure. He is inevitably a participant, and the entire field of social action is thus altered by his presence. Sullivan's approach is known as "field theory" in clinical therapy today.

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Heart Failing,System Ruling

S. N. Huynh

Mental illness to many people I know is a foreign disease, a disease which they are immune to because they are healthy individuals who have their sanity under complete control.

I was a Vietnamese interpreter/translator for seven years, both for the courts and hospitals. It was seven wonderful years because I got to know a group of very special people, offenders and the mentally ill, the group of people whom our society has regrouped as aliens. They were to be tattooed and locked up until they could be transformed to become one of us again. In my experience, a mentally ill person was not treated any different than a convict. He/she would loose his/her freedom, and had to wait for a trial and parole in just the same way.

Perhaps I am too simple minded, and too emotionally involved to fully understand our institutions. And I cannot agree with you more. I am not seeking to present a profound theory about mental illness. I am writing to you in hope to share with you a disturbance, which had pulled me closer to the person whom I did not know…myself…my uncaring and insensitive self. I come to know this person who only looks at another being as a "thing" which has become "messed-up." I come to know this person who would pretend to look at her own reflection as a foreign object. And I come to know this person who would believe that she was immune to mental illness.

When I recognized that person within me, I was not happy, but I did not need to pretend that I was never sad. There were many sleepless nights when I could not separate myself from my clients, their grief became my tears, their hope became my laughter, and their past became my history. I wanted to break those walls down to free them, to free myself. Then, I asked myself if I was becoming crazy too; because I found myself desiring to break all the social rules, which my clients had broken. I wanted to go crazy at times because I found this world is too cruel, and if I could go crazy I don't have to be in their world and feel the pain inflicted in their world…my world.

I tried very hard to convince the people of my world that these individuals who they had labeled as insane did not need to be locked away. They are "us." They need to be with us, and we cannot separate them. They are as much sanity as our insanity. Cutting them out of our will of love is like saying love is not pain. Cutting them out of our laughter is like saying laughter is not tears. Cutting them out of our embrace is like saying embrace is not departure…

I can only wish that I would always remember this when life would call on me to be there for the people who had helped me recognize my denial-self. I hope, when the time comes, I would not treat them as an object or a subject of a theory, a patient of a ward, or a client on my invoice, but as a being and as part of my identity. I hope I would always remember that they are in my world, and whichever ways they could express their pain, their pain is just as valid as my pain, and it is their pain, which must be understood and be elevated. Their pain should not be the motive for me to alienate them.

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Book Review:
Boyer's *Countertransference and Regression*

Robert S. Wallerstein, MD

Countertransference and Regression (1999) by L. Bryce Boyer, MD, Northvale, NJ: Jason Aronson Inc.

Bryce Boyer, although an unsung prophet in his home bailiwick – his own psychoanalytic society and institute – has been justly hailed throughout the larger psychoanalytic world for his four-decades-long pioneering in America of the use of the countertransference as the central therapeutic intervention in the successful psychoanalytic treatment of the borderline, and the over-the-border, frankly psychotic patient. And he has been a tireless expounder of this viewpoint in our country and around the world, with a particular presence in Latin America, where he has visited and taught so often that he has been made an honorary member of both the Argentine and the Mexican psychoanalytic associations.

This current book is his second volume of selected papers, published originally from 1983 to 1997, but edited recently for the purposes of inclusion as book chapters. The first volume, also of selected papers, titled *The Regressed Patient*, was published in 1983. The present book's title, *Countertransference and Regression*, captures simply the two main themes that Boyer articulates and hammers relentlessly: 1) that regressions, even psychotic regressions, usually (but perhaps never completely) confined to the therapeutic hours, should never be feared, but should be welcomed, and even invited, for providing the opportunity to relive and to detoxify the earliest traumatic and pathogenic infantile life experiences that have so profoundly shaped, and misshaped, the subsequent character development and personality (mal)functioning of these sicker patients; and 2) that the central therapeutic interpretive approach to the amelioration of the patient's tormenting conflicts, as discerned in the regressed state, lies in the interpretation of the countertransference – called by Boyer *through* the countertransference – which is defined as the impact upon the therapist's unresolved inner conflicts of the introjection of the patient's projective identifications. Indeed, this is seen by Boyer as the very essence of the transference-countertransference interplay, the mutual introjection of the other's projective identifications, a concept ascribed by Boyer to Herbert Rosenfeld, a British Kleinian pioneer in the full psychoanalytic treatment of the overtly psychotic, working at about the same time and in much the same manner as Boyer in this country.

To specify more precisely – the countertransference is declared to comprise whatever the analyst experiences during the analytic session, which all together constitutes his (or her) idiosyncratic introjection of the patient's projections and his (or her) predominantly unconscious reactions to that introjection. This includes all the analyst's stray, and seemingly irrelevant, thoughts, ideas, fantasies, and feelings, including physical and somatic urges and sensations. These are not to be seen as idle distractions but as key to the analyst's understanding (intuiting) the projection of the patient's unconscious into the unconscious of the analyst, as these introjections impact upon the idiosyncratic and still conflicted psychology of the analyst. And here Boyer regularly falls back upon Freud's 1912 technique paper on Recommendations, in which the analyst's evenly suspended attention is equated with the analysand's task of free association, and the analyst is recommended to turn his unconscious like a receptive organ toward the transmitting unconscious of the patient (Freud's telephone metaphor).

What is glancingly, if at all, attended to in Boyer's account is the issue of the uncontrolled (and so often indeterminate) possibility that the analyst's intuitions (based in some described instances on the self-analysis of the analyst's dream the night of an unclear analytic session) may simply be off the mark, fanciful and misleading. The episodes described in the book are of seemingly successful interventions through the countertransference conceived in this way, as described via the patient's positive responses, the subsidence of severe anxieties, and the revelation of previously undisclosed, or even unremembered, traumatic childhood experiences. Negative counterinstances are not portrayed. It is at this point that the majority of American psychoanalysts who have tried to limit their clinical practices to the more amenable, typically neurotic and perhaps moderately borderline patients, avoiding the even more disturbed and overtly psychotic, might question Boyer's more boundless therapeutic zeal and optimism.

Boyer's book also develops some related, and I feel subsumed, themes. He emphasizes that the (hopefully) controlled therapeutic regressions within which he tries to work will only be safely experienced within the treatment hour if an adequate enough holding environment (as described by Winnicott and Modell) has been established. He makes the point repeatedly that the primary need with these sicker and regressed patients is not for explicitly verbalized and transmitted explanatory interpretations but rather for a relationship with another person through which words can be found-- usually by the analyst-- for that which has not verbal language, involving experiences within the earliest preverbal *anlagen* of the mind. Boyer emphasizes often that he has come to experience, and to interpret, each analytic session as if it were a dream, with its day residue being the unresolved transference-countertransference dilemmas of the preceding session or sessions. And lastly in this recounting, Boyer also emphasizes his relative aggressiveness in searching for, and ferreting out, the repressed traumatogenic childhood experiences which--like Freud--he feels need to be recovered, articulated and reexperienced, and thereby detoxified, with their continuing grip upon the psychic present then

diminished or eliminated.

Given all this, what may come as a surprise within this overall account of the treatment of those so hard to treat, is Boyer's insistence that his is a classical (and even traditional) "orthodox" analysis with the patient on the couch (for the same reasons that Freud adduced), with few parameters (by which he means ego-supportive efforts) and with a tough adherence to the analytic frame-- an outpatient, usually four times weekly, treatment, with rare recourse to hospitalization in the event of life crisis. His is a firm feeling of sublimated love for his patients and an ebullient therapeutic optimism on their behalf. Though he occasionally acknowledges that there are some people beyond his efforts ("For some people, like chronic disorganized schizophrenics, it can't work," p. 245), for the overwhelming part his view is that ("if they [the therapists] have a good personal analysis and enough life *elan*, to be able to allow themselves to experience people's difficulties without being personally changed themselves, then there's nothing that cannot be accomplished in working with psychological problems." p. 247).

Boyer clearly has read and absorbed the great array of psychoanalytic literature around the world that is consonant with his views. He is lavish in his credits, especially to Bion and Winnicott, but also to Giovacchini, Grotstein, Ogden, David Rosenfeld, Herbert Rosenfeld, Searles, Tustin and Volkan. Laudatory forewords by Grotstein and David Rosenfeld, longtime associates of Boyer's, are included, as is a terminal chapter interview by Sue von Baeyer in which Boyer, invited to identify a few major ways in which his thinking had changed over the course of his life work, launched instead into a personal autobiographical narrative, revealing his painful and traumatic upbringing in a highly dysfunctional family with a periodically openly psychotic mother. Boyer actually ascribes his competence in dealing interpretively with the mental disorder in his psychotic patients to his capacity, developed by age four, to interpretively calm his mother out of her psychotic rages, and her violent threats directed at him, and at the entire household. Laura Doty is responsible for the felicitous editing job, making this into a readily readable book. This book will be especially useful and interesting to those analytic therapists who are not part of that psychoanalytic world that Bryce Boyer so richly represents.

(Reprinted, with the author's permission, from the San Francisco Psychoanalytic Institute and Society Newsletter).

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Notes from the New York Chapter of ISPS-US

Brian Koehler, PhD

The New York Chapter of ISPS-US first convened in 1996 and has been meeting regularly on a monthly basis since 1997. We had been meeting primarily at Paul Carroll's apartment until our membership grew from about 18 to close to 100 members. Each meeting is attended by anywhere from about 15 to 25 persons. We now have an institutional sponsor, New York University, in downtown Manhattan.

In the past year we have participated in case presentations by Leston Havens, Vamik Volkan, Joyce Aronson and Kerstin Kupfermann. We have heard papers on a personal history in psychiatry and psychoanalysis by Maurice Green, annihilation anxiety by Marvin Hurvich, phenomenology and schizophrenia by Louis Sass and James Ogilvie, and bipolar disorders by Brian Koehler. We have watched videotapes featuring Harold Searles and R. D. Laing, Bertram Karon, and Joanne Greenberg on her therapy with Freida Fromm-Reichmann. Presenters for the coming academic year include Anni Bergman, James McCarthy, Andrew Lotterman and others. Revella Levin suggested that we devote time to discussing countertransference anxieties in the psychoanalytic therapy of psychotic patients.

If you are interested in participating in our monthly meetings, please contact Brian Koehler at (212)533-5687 or bkoehler7@compuserve.com

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Column: Mind and Brain

Brian Koehler, PhD

For many years I have been greatly impressed by the large overlap of research findings in the neuroscience of schizophrenia, bipolar disorder, depression, PTSD and the neuroscience of profound chronic stress and anxiety. Just as there is an upward causation in brain-mind interaction, there is also downward causation. Also an important scientific caveat to keep in mind, is that correlation does not necessarily prove causation, i.e. the presence of neural changes in severe mental illness may reflect correlates, or perhaps even the result of experiential factors, such as impoverished or chaotic environments, poor nutrition, stress and anxiety. The latter are more salient factors when the individual feels a lack of control over the stressor and that the latter is not predictable (Akil & Morano, 1996). Fishman and colleagues (1996) reporting in the International Journal of Neuroscience demonstrated in rats that behavioral, psychogenic stress can result in DNA damage and chromosome aberrations. They noted:"behavioral stress can induce genotoxic damage on at least two levels, chromosomal and molecular, and in at least two cell types, bone marrow and leukocytes" (p. 224).

These observations may have direct relevance to psychoneuroimmunologic factors in various medical and psychiatric disorders, including cancer. The effects of uncontrollable psychological stress have also been studied during and after human gestation. Marta Weinstock (1997, 1998), from the Department of Pharmacology at Hebrew University in Israel, has demonstrated that prenatally stressed (PS) human infants and experimental mammals evidence dysregulation of the limbic-hypothalamic-pituitary-adrenal axis (LHPA), attentional defects, hyperanxiety, and disturbed social behavior. Weinstock hypothesized that maternal stress hormones induce long lasting changes in the developing fetal neuroaxis.

Neurobiological research on the fear system in mammals may provide some clues that have direct clinical relevance to our psychotherapeutic work with patients. Fear conditioning can occur primarily in the thalamo-amygdala pathway without any involvement of the cortex (e.g., the hippocampus), thereby unconscious processing of emotions may be the rule rather than the exception in our daily lives (LeDoux, 1999). Certain emotional states may posses us seemingly out of the blue. From an evolutionary perspective, the rapid subcortical processing of threatening stimuli is quite adaptive for survival. Therefore we may experience strong affects without higher cortical representation, i.e., feelings without content, and this seems to be particularly true in regard to the effects of trauma on memory. As LeDoux (1999), a prominent neuroscientist and professor at the New York University Center for Neuroscience, noted:

> "A traumatic situation in which an animal or a person is under stress, has separate consequences for these two kinds of memory systems [amygdala vs hippocampal mediated]. When the HPA [hypothalamic-pituitary] axis releases stress hormones into the body, the hormones (especially cortisol) tend to inhibit the hippocampus, but they excite the amygdala. In other words, the amygdala will have no trouble forming emotional, unconscious memories of the event-and, in fact, will form even stronger memories because of the stress hormones. But the same hormones can interfere with the normal action of the hippocampus and prevent the formation of a conscious memory of the event" (p. 142).

As Bolton and Hill (1996) pointed out, processes that appear imbued with non-intentional causality (physico-chemical) may interact with, or be masking processes of an intentional nature (fears, beliefs, anxieties, hopes,etc.).

Suomi and colleagues (1997), from the National Institute of Child Health and Human Development, studied the long-term effects of different early rearing experiences on social, emotional and physiological development in non-human primates (with which we share about 98-99 percent of our genome). They concluded the following:

I. That the brain itself can be changed by certain early experiences is strongly supported by the extant non human primate data.
II. The most dramatic manifestations of early experience effects seem to occur in the context of stress or challenge. An implication of this is that benign social and physical environments "can serve as powerful protective factors for individuals whose early experiences were far from optimal." (p. 113).
III. "Early peer-rearing and experience with variable foraging demands (and to a lesser extent) lack of control of access to desirable foodstuffs) seem to make monkeys more behaviorally and physiologically reactive and, for at least some...more impulsive as well" (p. 113). These finding seem to reflect deviant early experience over and above any genetic predisposition.

Suomi noted: "It is hard to believe that humans would not be at least potentially sensitive to the long-term behavioral and physiological effects of adverse early experiences as their evolutionary cousins appear to be" (p. 113).

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Letters to the Editor, cont.

From Grace Jackson, MD

Brian: I guess this could be a "letter to the Editor" for your next newsletter!!!! A "Reflection on D.C. " !!!!! waddya think?

There is a technique among attorneys that, for a defendant to even RESPOND to a ridiculously false charge is tantamount to conceding its validity. That is to say, investing ANY energy in responding to some allegations is discrediting. It seems that ISPS is caught on a treadmill at the moment, someone or something having decided ...consciously or unconsciously..... that it must assume the role of "VICTM" or "DEFENDANT" and answer the charge: psychotherapy is NOT effective. and even if it IS effective, it is too expensive. and even if it IS effective and affordable, it is UNSUBSTANTIATED by outcome studies and empirical verification. Well, so, too, is the existence of GOD, the belief in Heaven, a parent's belief that a 6-month old will eventually walk, or a beginning pianist's belief that he or she will ever advance beyond scales and arpeggios to a full Tchaikovsky concerto. Belief counts for MOST of the wonders of human achievement, yet.....in the field of WESTERN medicine and psychiatry, it is NO LONGER enough. In fact, it is NO LONGER ANYTHING. The conference was appalling to some newcomers I met. They told me: "I wonder why I came....I don't think this is the right organization for me"..... They were responding to the DEFENSIVE posture which seemed to permeate the room, as two speakers seemed to indict, if not impugn,..... the audience's allegiance to principles whose early history had just been thoroughly reviewed by the organization's president. It was suggested to the conference attendees that the BURDEN OF PROOF (for the effectiveness of psychotherapy) rested upon ISPS. This was shocking language." Burden of proof" assumed that ISPS was prosecuting someone or something, needing to "persuade a jury." Yet, it was ISPS that was "put on the stand" by the contents of the PORT report_ [specifically, Recommendation 22]. "Burden of proof" implies that those people who believe in the usefulness of psychodynamic principles, long term work, and attachment.....are GUILTY of doing something wrong or morally opprobrious. In FACT, the history of mankind might suggest otherwise... that it is the NIMH's of the world, the Eli Lilly's, Pfizers, and Roches.... who are in the "minority". When a Guatemalan family takes its' schizophrenic to the shaman and the community restores the person to "health," it is done without Zyprexa. When a Mexican family takes a schizophrenic to the Curandera, and the demons are exorcised, no Risperidone is used. These are cultures where families, community, and God still exist. Environments with no DSM, and no doctors who have been trained that people with "severe mental illness" cannot possibly "get well". Not unless they were misdiagnosed in the first place. Perhaps ours is a culture without mental health, because we have become alienated from the very things which heal in other allegedly "primitive" socieities... those things being: love, connection, and a worldview that gives meaning and purpose to the existential dilemma of being human with the ever-present knowledge of mortality. So why does ISPS keep acting defensive or apologetic for the very traditions and healings which pre-date Chlorpromazine by over 50 years? Perhaps ISPS would attract more members if -- instead of acting apologetic -- it kept focusing on the fact that psychodynamic treatments WORK, by giving demonstration after demonstration after demonstration (such as the poetic case report offered by Dr. Betty Oakes) of HOW it is , WHY it is that serious illnesses can be ameliorated or even cured. ISPS would seem to weaken its position when it ASSUMES the "wounded" identity that the biological reductionists project. For a projective identification to work, it takes "two to tango". One wonders if ISPS has accepted the role of "psychotherapy dinosaur", out of "collective guilt" that the longest practitioners of analytic methods truly HAVE catered to an elite clientele, and so have failed to reach the homeless, penniless masses.... Does ISPS attempt to atone for some economic or sociocultural transgression when its members dignify the outrageous claims of the biologists, by echoing their call for "more research" and "more outcome studies", to prove what its members intuitively, deeply, and most convincingly already "know".Perhaps the healing potential engendered by those therapists who approach not only brain, but also mind reflects an entity that is immutable but strangely immeasurable. Recalling the aesthetic beauty of a Little Prince's precious rose, might this not be an important time in history to remember the words of St. Exupery: "the most important things in the world remain ...invisible".

Grace Jackson, MD

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From Cathy Penney, RN

Dear Brian-

Great newsletter! It would be interesting if someone could address the impact creativity may play in a persons recovery, whether it be through art, music, dance, or poetry. For a lot of persons who have experienced psychosis and are just beginning to get back into the world again, creative expression, evan if it is done alone, in the privacy of their own room, can provide a safe place for them to get back in touch with their feelings and emotions. In the case of dance, it can also help a person become re-familiarized with their body , seeing it and experiencing it in a new and positive way.

Regards,
Cathy Penney

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The Role of Aggression in the Development of Schizophrenia

Harold R. Stern, Ph.D.

The purpose of this paper is to describe a particular theory along with an operational approach for the treatment of schizophrenia. It is mainly the issue of transference and counter-transference that makes the treatment of the schizophrenic patient so challenging a procedure. Essentially, treating schizophrenia involves working with someone who has difficulty or is unable to cooperate, communicate reasonably, follow rules of treatment, and for whom there is little or no object constancy. The transference observed is a narcissistic one, something that Freud viewed as a part of a group he termed the "narcissistic neurosis". In his early work he saw the narcissistic neurosis as a problem of the libido having been withdrawn from objects in the outer world and invested excessively and self-directly towards one's own ego. This narcissistic transference is much different than object transference because there is no observable external object to project upon. This kind of transference is difficult to recognize since it is the self that is the object. Even when it is so recognized, there typically seems to be no way to resolve it. What we observe in these patients are symptoms of withdrawal and grandiosity. Early on for psychoanalysts, this picture created an impasse. Analysts using the classic approach to treat schizophrenia found that these patients remained frozen in a state of narcissistic self-involvement or got worse. Such patients were unable to develop the needed object libido and achieve an object transference toward the analyst.

This theoretical impasse was resolved when Spotnitz (1985) correctly observed that the core issue for these patients was not libido turned inward towards the self, but rather aggression that had turned inward towards the self. He theorized that they suffered not from too much self-love, but rather from excessive self-hate. His development of a clinical approach for the treatment of the "narcissistic neurosis" became the focus of his modern school of psychoanalysis. In his early work with schizophrenics, Spotnitz found that given certain conditions and contrary to the prevailing classical opinion, they were able to develop strong transferences, but of a different kind than those found working with neurotic patients. These were narcissistic transferences in that the patients were very self preoccupied and the analyst was perceived as part of the patient's self rather than having separate thoughts and feelings. These transferences replicated the processes of the early years of life and therefore were insightful to the analyst of the patient's early destructive experiences. He avoided using the usual classical techniques of free association, interpretation, and confrontation. Rather, he cultivated the narcissistic transference. Instead of interpreting the ego defenses, Spotnitz developed special techniques such as joining, mirroring, and reflecting in order to strengthen their fragile, fragmented ego structures that were typical of these schizophrenic patients. Until the patient becomes strong enough to function without his prior structure of defenses, the analyst needs to reinforce or join these defenses.

There are some basic general principles involved in the recognition, application and use of technique for working with the narcissistic neurosis: primarily, we study the negative narcissistic transference, anger that is turned destructively against the self, anger that is turned destructively toward others, and very importantly, the problem of the therapists negative narcissistic countertransference. Without the therapist having some understanding for the management of his own feelings, as well as some basic techniques, a positive outcome in the treatment of schizophrenia is not optimistic.

As Freud had observed long before, Spotnitz realized that in working with the narcissistic disorders, the analyst could not count on a positive object transference and a cooperative rational ego, basic elements that are essential to the successful treatment of the neurotic patient. In summary, it was clear that such patients were not suitable candidates for psychoanalytic treatment using tried and true classical techniques. To Spotnitz, however, this did not mean schizophrenic patients were beyond the reach of psychoanalytic influence. Such patients have both a functioning ego, though limited, and observable defenses and therefore might be reachable using other approaches. The situation required special careful study and attention. Gradually what Spotnitz developed were techniques more suitable for these patients that could accommodate to their defenses. At the same time he did not abandon the basic psychoanalytic approach of working with resistance and transference. It was, however, different than the transference resolution approach used in treating the neurotic patient, i.e., interpretation. His efforts resulted into what is now included in the Modern Analytic approach to working with severe narcissistic disturbances. This approach involves important basic theoretical modifications as well as some novel clinical applications that will now be described.

We can begin by describing the essence of the theory. No problem has occupied the thinking of Modern analysts more than that of aggression that is turned toward the self. The destructiveness of this aggression against the self can be of life threatening toxic proportions. Spotnitz viewed the schizophrenic as having had to invoke what he termed the narcissistic defense, an early childhood strategy that was invoked to avoid destroying an important object in the child's life. This boomerang process protected the valued object from murderous rage by directing the rage against the self. Aside from this defense being part of the makeup of the schizophrenic personality, it is also invoked in the often-disguised self-attacks we observe in depression, various somatic illnesses, eating disorders and other self-destructive processes. Defenses against external anger can also be manifested in many other crippling mental illnesses that block normal maturational pro-

cesses and positive relationships between people.

The narcissistic defense warrants some further discussion. As a phenomenon that develops in early life because of fears that the outward release of anger or hate would lead to the loss or elimination of a relationship with a critical person in the child's life, a complex series of other defenses are invoked by the ego. Some of these fears may include omni potently destroying the object leading to fears of retaliation, to self-destruction, abandonment or devastating rejection. There can also be the magical fantasy that the hatred of the valued object will destroy the "goodness" in that object and lose for the child the potential for a hoped for loving relationship.

These fears in patients, who are fixated at a pre-oedipal/narcissistic level, set the stage, particularly at the beginning of treatment, for the need of a special kind of therapeutic environment. In essence, it is an environment where it is safe for the patient to "say everything". It is the first step in a process that will enable the patient to feel secure putting all feelings and thoughts into words without the fear of any action either from the analyst or from the self. It will ultimately lead to the creation of a significant emotional relationship that allows for the mature development of the patient and an eventual cure. Techniques are implemented that will enable the patient and therapist to achieve a safe and stable relationship, one that will be free of the threat of collapse or abandonment. All of this is designed to allow for prior life-long self-directed aggression to be put into words and externalized in the safety of a carefully scripted treatment situation. This makes possible an eventual transition from the embedded narcissistic transference to a more mature transference relationship and then to genuine relationships with an external objects. These techniques should importantly take into sensitive consideration the ego defenses. Because the defenses in the schizophrenic patient are quite fragile, the therapist must take care to maintain and even to strengthen them through the use of certain techniques. Briefly, these techniques are as follows:

The patient's attitudes and perceptions are not challenged, but rather are joined and mirrored. Carefully, the analyst may make comments or ask questions in a neutral way that will reflect or accord with the patient's views. As mentioned above, while Freud saw the narcissistic transference as an impediment to analytic treatment, in Modern analysis the development of this transference is encouraged to develop in order to allow the patient to feel that the therapist is like him, i.e. a mirror image of his/her ego. Thus, all such behaviors by the therapist are intended to strengthen, enlarge and promote the narcissistic transference to allow the patient to feel that the therapist is someone like himself. Eventually, he may be able to relate to the therapist in a way that allows both feelings of love and hate. Gradually he can become comfortable and grow in the treatment just as the child should have been able to do with the original parent. As the maturational growth process proceeds within the therapeutic relationship, there is increasing the possibility for the interpretive comments that are customary and shared in a normal analytic relationship, but this can only occur after the narcissistic transference has been resolved.

Because the origins of the patient's condition lie in the early pre-oedipal period, a time that is often pre-verbal, words by either party are often without cognitive meaning. This negates the usefulness of attempting to engage in meaningful verbal exchanges with the patient of a mature nature. Therefore, emotional communication becomes the basic means of interchange. The feelings induced in the analyst and feelings aroused in the patient are the significant factors leading to change and progress. Words in common usages that are signifiers and are often based on symbolic and referred meanings, are for the pre-oedipal patient often potent and laden with concrete significance. Words, for example, do not merely describe destruction; they can in themselves destroy and therefore are for the schizophrenic patient often eliminated from social interchange. This limitation in the treatment needs to be remedied by educating the patient to say everything in a therapeutic climate that is not only safe, but also healing. Since free association, interpretation, and insight are initially counter-productive, the goal becomes to simply get the patient to talk by resolving the resistances that block progressive verbal communication. The modern analytic treatment becomes a method of investigation rather than a method of explanation. Instead of explaining the patient to himself, the patient is helped to put his thoughts and feelings into words. Consistently, the analyst attempts to lead the patients thinking into the object world. This is done by avoiding questions and comments to the patient's ego field, but instead shifting them to the object field. The focus is away from the patient's inner processes and out to the external world. Another Modern analytic technique involves "contact functioning". In general, the analyst may avoid direct approaches to the patient and instead wait and allow the patient to reach out to him, thus again fostering movement toward the object world. Constantly widening the scope of the patient's sphere of psychic content into language integrates and strengthens the patient's ego. Furthermore, this resultant increasing of emotional interaction with the therapist leads to important maturational progress.

These maturational progressions are not only powerful for the patient, but also for the analyst. The expression in words by the patient of his previously repressed aggression, of hatred toward an introjected object, now directed towards the analyst during the session, feelings that were previously locked in a seething container, can put the therapist into a violent storm of feelings that can range from powerful hatred for the patient to depressive hopelessness and loss of faith in his ability to achieve any success in healing any patient, let alone the one he is treating. Like Ulysses tied to the mast, the analyst must ride out this storm and hold to the course. Unlike the patient, the analyst must have a rational observing ego that enables him to objectify the verbal missiles being hurtled towards him and viewed as a welcome projection of what has formerly been toxically introjected.

I now have a patient who has been in treatment with me for four years that I shall call Carol. She is in her thirties, has five appointments each week, has been hospitalized three times, has been diagnosed as schizophrenic by many doctors, and sexually

continued on next page

Aggression, continued

known many men and has had six abortions. Prior to me Carol has been treated by many doctors, many of whom have discharged her as untreatable (and I suspect unbearable to be with). In a one-year period she was treated by at least ten dentists. She felt that each one was either trying to hurt her or were unsuitable. She has yet to find a dentist that she can cooperate with.

Since from almost the beginning of treatment Carol has threatened and promised to commit suicide. During the first three years of treatment, there was much acting out, untimely and unwanted visits to my office, frequent phone calls, and much abusive language and treatment of me. At the same time there was much self-destructive behavior, much of it towards her body that included the above-mentioned abortions. Consistently, she would do self-damaging things, and then accuse me of having caused them. There were constant threats of bringing legal actions against me for numerous crimes. There was little I could say that would escape her flaying criticisms and lethal scorn. It would be useful to point out that Carol came to me in a state of extreme distress after being discharged by her previous female therapist. I have the clear impression that this previous therapist received little if any of the aggression that has been unleashed towards me. My sense is that the previous therapist having resolved much of the narcissistic self-aggression, allowed this aggression to now be outwardly directed and to be unleashed upon me. In most of the sessions I sit attentively quiet waiting to intervene with a object oriented question or comment that may resolve the particular resistance I am concerned about

. For example, I concluded that Carol was still not emotionally toilet trained and that somehow I needed to work on this. My opportunity came when she was relating how her cat frightened her house cleaner and would not let the frightened lady do her job. I said in a very definite voice, “That cat is not toilet trained!” Carol then raged at me, “You don’t know what you are talking about. It is not a question of being toilet trained. The cat is like me. Just very spoiled. And there is nothing we can do about it now. It is too late.” Gently and little by little I have been teaching Carol to understand the rules of treatment. She needs to understand them and to follow them, and eventually to be comfortable with them. Getting Carol to attend her sessions on time, lay on the couch and not jump up, leave on time and pay on time is a big challenge for the treatment. Like most of my schizophrenic patients Carol uses the couch. (Stern 1978)

The focus in this paper is on the theories and techniques of the Modern analyst to explain the role of aggression in analytically treating a certain type of patient. In those situations where an analyst cannot count on a patient’s genuinely cooperative and competent observing ego to absorb interpretations constructively, the methods developed by Modern Analysts can usually be more effective than rational interpretations directed to the ego. Although this paper leans on these peculiar theories and techniques, it needs to be emphasized that Modern Analysts do not limit themselves to only these approaches that can sometimes be viewed as manipulative.

Bibring (1954) writes about a “shift in emphasis from insight through interpretation to experiential manipulation." It seems to have become a common trend in various methods of dynamic psychotherapies. Alexander and French’s (1946) statements may serve as an illustration of this shift: “insight is frequently the result of emotional adjustment and not the cause of it.” And: “The role of insight is overrated.”

In treating the schizophrenic patient, we do not seek insight. We strive for emotional growth and development through an experiential relationship with the analyst aimed at helping the patient’s ego to grow by being able to “say everything”. This, among other things enables the safe and healthy release of inhibited aggression.

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Regression: The Dilemma of *The Yellow Wallpaper*

Julie Kipp, MSW

In my research for a dissertation on the subject of regression, I came across two points of view on a specific pre-psychchoanalytic regressive treatment from the past. One voice is that of Ian Suttie, an early British psychoanalyst. His 1935 book, *The Origins of Love and Hate* (Suttie 1935), is still referred to with much respect, though long out of print. The other voice is that of an early nineteenth century feminist, Charlotte Perkins Gilman, from a short story she wrote entitled *The Yellow Wallpaper* (Gilman 1973).

Suttie, in *Origins of Love and Hate*, refers positively to the late 19th century American psychiatrist S. Weir Mitchell, who was famous for his rest cure for hysterics. Suttie reports, "This regime virtually surrounded the patient *with the environment appropriate to the infant.* Food was good and abundant; silence and darkness encouraged unbroken rest; attendance was unremitting; but conversion was discouraged except during the daily visit of the physician, which - I understand - lasted an hour. Not one has been able to repeat Weir Mitchell's results; and why? I have read the suggestion that it is because we cannot afford the expense of his type of establishment. This is sheer nonsense. I consider myself that our failure to get his results *with his* treatment is entirely owing to our total misconception of the "modus operandi" of his regime. From our materialistic point of view, we usually try to interpret his cures as bodily responses to *material* treatment (over-feeding); but over-feeding, 'per se', does not cure hysteria. The giving of food is, however, for the child, a sign of love, so that over-feeding will have incidental psychological effects. So far as we admit a psychic factor in Weir Mitchell's success, we tend to regard this as due to the *coercion* of the patient by *privation* of adult interests and pleasures. I would suggest that, on the contrary, the Weir Mitchell treatment represents a gigantic *indulgence* (and thus a reassurance) offered to the *unconscious baby-self* of the patient. It is a reinstatement of the friendly "nursery" environment. That it is disagreeable to the adult personality is merely incidental and immaterial, as also is the fact that it *reinforces* adult desires and wishes by inforced (sic) abstinence. By taking the illness seriously Weir Mitchell won his patient's confidence and was able to ask him - without words, but effectively - "is this what you really want?" The Baby-Self, if I can personify it, was satisfied and reassured by interest and attention and became willing to leave mothers' lap and recommence its *play*. The adult self could heartily answer "No". The need-for-illness was here . . . appeased by kindness - but by a *kindness addressed to the regressive infantile longings. Once confidence is restored at this level, the need for 'nursing' is appeased and the natural attractiveness of adult life returns*" (Suttie 1935 p. 172 - 173, his italics).

Thus in Weir Mitchell's treatment the patient is encouraged to regress in a kind, warm, undemanding environment until such time as (s)he is ready to return to adult functioning. The patient feels that his/her illness is taken seriously, and there is room to experience it, not to deny it, to get better at one's own rate, and according to one's own decision as to the time to reembrace adult life. This represents an approach to the patient which includes much that I find missing from our current treatment settings.

However Charlotte Perkins Gilman had a very different reaction to Weir Mitchell's treatment based on her own experience as one of his patients. She became aware of the injustice of women's lives early in her own life, when her father abandoned the family, perhaps because her mother had been told that her health did not permit her to have more children. Her mother evidently reacted by becoming cold and unapproachable with her children:"it was her way of initiating Charlotte into the sufferings life would hold for a woman" (Hedges 1973 , p. 42). Gilman herself suffered from serious depressions throughout her very productive life. After the birth of her own child, she became depressed and was sent to Dr. Weir Mitchell of Philadelphia, "the most preeminent 'nerve specialist' of her time" (Hedges 1973, p. 46). "(I)t was his patronizing treatment of her that seems ultimately to have provoked her to write her story" (Hedges 1973 , pp. 46 -47). Her story, *The Yellow Wallpaper*, is a chilling tale of a woman's growing madness, which is escalated by a rest cure like that of S. Weir Mitchell. The protagonist, a woman with a new baby, evidently of a comfortable social standing has "a temporary nervous depression - a slight hysterical tendency" (Gilman 1973, p. 10). She says that she is required by her husband and brother, both physicians, to "take phosphates or phospites - whichever it is, and tonics, and journeys, and air, and exercise, and am absolutely forbidden to 'work' until I am well again" However, "personally, I disagree with their ideas. Personally, I believe that congenial work, with excitement and change, would do me good. But what is one to do?" (Gilman 1973, p. 10). Her husband is "very careful and loving, and hardly lets me stir without special direction" (Gilman 1973, p.12). Left alone much of the time, too anxious to care for her own baby, forbid any stimulating company, the ill woman becomes increasingly and psychotically engrossed in the ugly yellow wallpaper of her bedroom. In the Afterword, Elaine Hedges writes, "this woman, whom we have come to know so intimately in the course of her narrative, and to admire for her heroic efforts to retain her sanity despite all opposition, never does get free. Her insights, and her desperate attempts to define and thus cure herself by tracing the bewildering pattern of the wallpaper and deciphering its meaning, are poor weapons against the male certainty of her husband, whose attitude toward her is that 'bless her little heart' he will *allow* her to be 'as sick as she pleases'" (Hedges 1973, p. 52, her italics).

Thus, for Charlotte Perkins Gilman, Dr. Mitchell's treatment was a horror and an inducement to complete mental breakdown; a way of punishing a woman already sickened by the limited opportunities of her life, by depriving her of almost every privilege.

It seems that one person's opportunity to withdraw and reintegrate, kindly given and gratefully received, is another person's repressive regime, exacerbating mental illness. The regres-

continued on next page

Regression, continued

sive treatment is viewed as a kindness by the practitioner, while the recipient of the treatment, the patient, feels wrongfully constrained (although also feeling that she should be grateful for the "careful" and "loving" treatment). This is certainly not always the case: other patients *have* felt grateful for the chance to regress. Mary Barnes felt very strongly that her chance to regress very literally to an infantile stage at Kingsley Hall under the care of R. D. Laing and Joseph Berke was crucial in her recovery. Margaret Little joined the queue lined up to experience a regression to dependence with D.W. Winnicott, and greatly appreciated her treatment with him. Joanne Greenberg wrote a fictionalized version of her treatment at Chestnut Lodge with Frieda Fromm-Reichmann,where she spent several years, with periods of regressed functioning. Certainly not all practitioners advocate regression, nor the conception of the patient as childlike, and some have spoken strongly against the encouragement of regression in treatment. Fromm-Reichmann herself felt that it was important to address psychotherapy to the adult portion of the schizophrenic person, "rudimentary as this may appear in some severely disturbed patients" (Fromm-Reichmann 1954 , p. 411). The psychotherapists and theorists of Chestnut Lodge present an interesting paradox in this area. Historically patients at Chestnut Lodge received lengthy in-patient care with several times per week psychotherapy: by all standards of the rest of the world, a rather regressive treatment. But Chestnut Lodge theorists tend to caution against the over indulgence in regression. (This generalization doesn't apply in the work of Harold Searles, however.) Perhaps this makes sense in light of the regressions already tolerated by the environment there: that is, when the environment allows for necessary regression, the therapist has the opportunity to emphasize the adult within the patient self. As Suttie says, with the "Baby-Self" well provided for, the adult self can be challenged to go on to address the question, Is this what you really want? and perhaps come to be ready to answer "heartily. . . 'No.'" However, in contemporary settings where such regressive environments are very seldom available, Fromm-Reichmann could be misread. If she cautions against regression in the context of work at the mid-century Chestnut Lodge, it certainly has a different significance when read by a practitioner working in a contemporary city hospital, where patients are discharged as quickly as possible, with little asylum given, little regression tolerated.

To return to my example of Ian Suttie's reading of Weir Mitchell vs. Gillman's experience of Weir Mitchell's treatment, the juxtaposition of examples points out a certain political aspect to the consideration of regression in treatment. Any treatment relationship necessarily includes issues of power and authority. This is certainly more so in our treatment of people who are so seriously mentally ill that they are unable to function at an adult level. Gilman's experience highlights a paternalism towards women who were considered as child-like and less than full adults even when not mentally ill. She chaffed at a treatment which prohibited her the exercise of all her resources - in her recovery, or in her life. Treatment has the potential to perpetuate a status quo which could be used, consciously or unconsciously, against peoples of ethnic and cultural minorities, as Gilman saw happening to women around the turn of the century, and as still occurs in our own day.

It should be noted that Weir Mitchell's regressive treatment was pre-psychoanalytic. Gilman's heroine is forbidden many adult responsibilities and pleasures, but on the other hand she is also forbidden from discussing her illness, which her husband evidently feels is to indulge herself in it. She is expected to restrict her life even more than her depression already limits it, but she is not allowed to attribute her failings or current inabilities to her "nervous condition...(since) John says if I feel so, I shall neglect proper self-control" (Gilman 1973, p. 11). None of her worries or "fancies" can be discussed, so it seems that she is in a double bind, in which she is forced to live the life of an invalid, but forbidden to discuss her illness. Thus the treatment leaves her abandoned with her troubles, and ultimately, with her insanity. A therapist with a psychoanalytic understanding of regression would not have made this particular error, and would have in fact focused on finding a way to help the patient to discuss her feelings.

The comparison of these two works highlights questions about the place of regression in treatment which continue to challenge us: what aspects of regression might be helpful, and under what conditions? when is regression anti-therapeutic? It seems that part of the answer has to do with the patient's ability to have some choice. Gilman's heroine would have chosen to write, without feeling she had to hide it from those who were "caring" for her. She would have liked to choose her own room in the house, and she would have chosen a room downstairs which "opened on the piazza and had roses all over the window, and such pretty old-fashioned chintz hangings! but John would not hear of it" (Gilman 1973, p. 12). This was a room presumably closer to the center of the household, although she was clear that she was not able to be responsible for the household yet, or, by her own admission, to care for her baby. To what extent is choice possible for those patients who are not able to take responsibility for themselves?

This juxtaposition of views shows some of the complexity of thinking about regression in treatment of people with serious mental illness. Current treatment practices privilege rehabilitation, restabilization, use of medication and poly-pharmacy, and self-help approaches over psychotherapeutic treatment approaches which might make more room for the ubiquitous phenomena of regression, and this is a problem in my opinion. However it is apparent in this example that the concept of regression is complex, and the accomodation of its vicissitudes in treatment has potential for abuse and failure, as well as for reintegration and recovery.

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edited: Brian Martindale,
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published 2000 by Gaskell
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