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Aggression in the Therapy of Schizophrenia*

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It is a great pleasure to present the O. Spurgeon English Honor Lecture, especially since it coincides this spring with the hundredth anniversary of the discovery of the "talking cure" by Breuer's now celebrated patient Anna O. In preparing for the occasion, I did a little investigation of the individual for whom the lecture series was named and found, to my surprise, that Dr. English and I have repeatedly crossed trails physically, intellectually, and emotionally. We have had many common experiences, interests, and associations.

I understand that Dr. English came to the conclusion at one time that the best way to understand personality was through Freudian psychoanalysis. I came to the conclusion that the best way to understand schizophrenia was through psychoanalysis. Investigations of schizophrenia and psychoanalysis then convinced me that it would be possible to treat schizophrenia successfully through analytic therapy.

The first patient I treated as a resident at the New York State Psychiatric Institute was a young woman who had been hospitalized following an acute psychotic episode. This case illustrates how misleading appearances can be in the diagnosis of schizophrenia. On admission, the patient had appeared to be an anxiety hysteric. A

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little later the staff diagnosed her as a manic-depressive and, finally, as a catatonic schizophrenic. It was at that stage that I began to treat her. I developed a strong drive to cure her and spent several hours a day on the case. After a few weeks of treatment, she impressed the staff as behaving again like a manic-depressive, and later like an anxiety hysteric. After thus reversing the sequence, she appeared to be normal, and was discharged from the Psychiatric Institute at the end of six months.

In presenting this case at a staff conference shortly after it had been assigned to me, I reported on my attempts to establish some emotional contact with the patient, and some of her humorous remarks, at which I had laughed. Dr. Karl Menninger, who was visiting the Psychiatric Institute that day, said to me, "Don't laugh when your patient laughs, or she will feel that you are ridiculing her." I stopped laughing. My serious demeanor and investigative attitude, however, did not please her too well. One day, in fact, she picked up a massive ashtray and hurled it in my direction. It missed my head by just a few inches. When I asked her how she happened to miss, she said, "I still like you." I suggest that you make sure your patients like you before they decide to throw ashtrays at you.

My subsequent work led me more and more to treat schizophrenic patients. I worked with the late Dr. Phillip Polatin at the Psychiatric Institute, and we succeeded in reversing schizophrenic psychoses with ambulatory doses of insulin. Similar results were achieved with intravenous insulin and sodium amytal, also administered intravenously. Our experiments were significant in demonstrating the *chemical* reversibility of schizophrenic psychosis—the temporary reversibility of the psychotic reaction. Daily doses of insulin held the psychosis in abeyance; as soon as these were discontinued, the psychosis returned. Insulin did not change the disposition for schizophrenia.

Subsequently Dr. John Rosen demonstrated time and again the *psychological* reversibility of schizophrenic psychosis. An acute psychotic state is forcibly suppressed through Rosen's method of direct analysis, in which the patient is subjected to psychological attack to enable him to come out of the psychosis. After closely observing Rosen's clinical work, Dr. English expressed reservations about the

aggressive handling of the patient, pointing out the need for a "better means" of bringing to consciousness the defensive fantasy life of the patient **(English et al., 1961)**. Coincidentally, this observation was published during the year when I reported a different way of handling the aggression of the schizophrenic patient **(Spotnitz, 1961)**. This approach enabled me to demonstrate to my own satisfaction that the schizophrenic reaction was psychologically reversible on a sustained basis.

Years earlier, when I started to treat these patients, it was fortunate for me that my personal psychoanalysis was under way and that my analyst was able to handle successfully any tendencies I may have had to develop psychosomatic or psychotic symptoms in the course of working with many schizophrenic individuals. Anyone who wants to work with them must be prepared for the possibility of incurring psychotic symptoms, notably the rage reactions that these patients tend to induce in the therapist. In the literature, these induced feelings are commonly described in terms of countertransference psychosis. Schizophrenic patients tend to mobilize a great deal of aggression, and working with them can have disastrous effects on insufficiently analyzed practitioners.

The impression I had gained from the works of Freud and others was that the primary problem of these patients was either self-love or anxiety, or both. But after more than one patient started to tear my office apart and others came at me with knives and guns, I became convinced that their nuclear problem was the danger of engaging in destructive action, a danger of which they usually were more or less aware and tried to avert at all times. I could see that a therapist working with such patients might be justified in having a great deal of anxiety. I was interested in seeing to it that they did not make me the target of destructive action.

The method I thought would be most effective was to keep them on the couch. The couch is, at least in a psychological sense, a lair that assures the therapist of some protection against attack and alerts him to the possibility of aggressive behavior if the patient gets off the couch. It is my personal admonition that the patient be on the couch when one employs the techniques advocated by my colleagues and myself for the treatment of schizophrenic patients; they

are more apt to act on their impulses and feelings when they are off the couch. One needs to bear in mind that the narcissistic defense helps the patient keep in check a great deal of aggression.

Understanding that the primary problem to work on is aggression and the sharing of that understanding with the patient does not reverse the schizophrenic reaction. The therapist has to learn how to deal with the aggression. This is not purely a matter of technique; it also requires emotional understanding and emotional communication—in other words, technique charged with emotion. When one employs emotional communication oriented to *resolving the patient's resistance to communicating his aggression in language without action*, the patient improves.

When the treatment is based on the operational theory and techniques that my colleagues and I worked out over the years (modern psychoanalysis), the schizophrenic patient may initially develop a negative transference to the analyst. A negative transference climate usually enables the analyst to work on the problem of aggression. The problem is approached in terms of resolving the patient's negative transference resistance **(Spotnitz, 1969)**.

As you know, the transference relationship is an especially humiliating one for the schizophrenic patient because of his extreme narcissistic sensitivity. The patient is asked to lie on the couch and talk, and nothing much is apt to come back in the way of response but words. This is a situation in which the patient becomes very frustrated. It is generally accepted today that the frustration should be kept within an optimal range by regulating the quantity of communications from the analyst. Otherwise, one secures either no therapeutic movement because the patient is securing too much gratification, or emotional explosions that may lead to destructive action, such as jumping off the couch, damaging furniture, hurling objects, and engaging in other behavior that can imperil the relationship.

Working with the schizophrenic patient therefore dictates a carefully controlled situation; that is, the analyst works sensitively with him. The patterns that the patient presents are studied (analyzed silently) and decisions are made on what interventions to use in order to resolve his repetitive communications. These repetitive communications can be terribly annoying. Student analysts have

told me, "I want to get rid of that patient. There's no point in having him around."

It is more or less accepted now that a great deal of narcissistic rage is imprisoned in the schizophrenic personality structure. This rage interferes with the interpersonal functioning of these individuals because they do not have channels for releasing it appropriately. They need an analytic relationship in which their resistance patterns are slowly modified, they can develop new channels to express their rage, and, in general, become well functioning and emotionally mature individuals. The maintenance of such a relationship requires great delicacy on the part of the therapist as well as an awareness of his own destructive impulses while working with the patient. In supervision, one has to help the student experience what is going on in himself in relation to the patient.

In reaction to the transference of the schizophrenic patient, the analyst characteristically develops various types of countertransferences. A type that is usually antitherapeutic is the subjective countertransference, in which the patient's emotions are reacted to in a highly idiosyncratic manner. In the objective type of countertransference reaction, the patient's early feelings for his mother or father or the patient's feelings for himself may be induced in the analyst. If these countertransference emotions are unrecognized and acted on, the analyst is incapable of working successfully with the patient because of the counterresistance they arouse. Some people equate acting in terms of their feelings with being genuine and helpful, but the feelings that one gets in treating the schizophrenic patient are not necessarily helpful feelings. They may, in fact, be damaging to both partners.

Another complication is created by the narcissistic nature of the patient's transference—the so-called narcissistic or self-object transference. The associated countertransference reactions to a patient in that state are confusing; often the therapist will not recognize that the patient is inducing his own feelings in the therapist. It is my impression that much of the barbarous mistreatment and mutilation to which psychotically ill individuals have been subjected over the centuries has resulted from the fact that they induced their own destructive impulses in their contemporaries. Those trying to help these unfortunate beings had no awareness that this was taking place.

In a state of narcissistic countertransference, the therapist may experience feelings from the patient that do not seem to be associated with the patient in any way. I was first alerted to that phenomenon when a friend came to the office and requested a neurological examination. He said, “I have a patient with multiple sclerosis, and I think I'm getting it too.” I examined him thoroughly but found no sign of multiple sclerosis. Situations like this occur over and over again in the relationship with a schizophrenic patient. He will communicate feelings of being lost, of indifference or of hopelessness, and the analyst will begin to experience the same feelings without necessarily connecting them with the patient. Because of the difficulty of accounting for them, it is a significant advance when the therapist is able to connect these feelings with the patient.

What the patient tries to “prove” during the first year or so of treatment is that he is a hopeless case, incurable, and that there is nothing you can do for him except to help him die. When you experience that feeling too, it is important to know that the patient has succeeded in inducing in you a narcissistic countertransference. As you become aware of it, the immediate task facing you is to determine how to respond verbally to the patient's communications.

Characteristically at that time the most prominent of these communications center around the patient's attempts to get out of treatment—his treatment-destructive patterns of resistance. One of my favorite examples of such resistance was demonstrated by the man who asked at the end of each session, “Is this our last session?” I would answer, “It certainly looks like it.” Then, as he left the consulting room, he would turn around and say, “Shall I come back next week?” “Why not?” I would reply, “What have you got to lose?” After persisting in this verbal routine for five years, the patient remarked one day, “I don't think you're going to discharge me.” “I think you're right,” I told him.

Treatment-destructive resistance also operates in group situations **(Spotnitz, 1976)**. A member of one of my current groups has been threatening to withdraw; session after session, she has announced her impending departure. Another member of the group, in an individual treatment session yesterday, criticized me for not intervening when these threats were made. “You haven't lifted a finger to keep that patient in the group,” she said. “If not for the group, she would

have left.” “What's so bad about that?” I asked. “Why shouldn't the group keep her rather than I?” She said, “I don't think you planned it that way.”

Actually, it is preferable that other group members, rather than the therapist himself, respond to the threats of narcissistic patients to drop out of the group. In the ideal group situation, the members cure themselves while the therapist collects his fee

and feels like a psychopath. If you cannot tolerate feeling like a psychopath and a schizophrenic and a manic-depressive psychotic and a pervert, you are courting trouble with these patients. Any feeling you object to, they will make sure that you get. Similarly, in the course of individual treatment, if you can't resolve your resistance to working with one or another feeling induced by the patient, you have been defeated. The patient wants to defeat you and leave you and have the satisfaction of telling the next analyst, "That bastard couldn't cure me."

You will encounter patients with whom you work productively for a period of time but who, sooner or later, deprive you of the satisfaction of completing their treatment. They will leave you and go to somebody else. I have worked successfully with patients who came to me from other analysts; I have also had patients leave me and secure good results with other analysts. One takes these eventualities in stride. But please don't recommend another analyst to a patient leaving you; to do so is to put a curse on that analyst. It's desirable that the patient be free to select the next practitioner he will work with. Patients did not have the privilege of picking their parents, but they ought, at least, to be permitted to pick the analyst with whom they want to get better.

Dealing with countertransference resistance requires personal analysis, self-analysis, or both. Every time you have a feeling that you are not able to understand and master, you may have to analyze it yourself by saying whatever comes to your mind while lying on a couch, sitting in a chair, or taking a walk. If you have a recorder, it's helpful to put what you say on tape and study it a few weeks later. Or you might do what I did years ago; as I have told you, I would go to my analyst, free associate, and let her solve the problem. What I do now, when I really am in a quandary, is to consult my advanced patients.

I remember getting into trouble with a young woman I treated many years ago because I asked her a few questions. She said, "Please don't ask me any more questions." Why not, I asked her. She explained that, after undergoing an appendectomy in childhood, she had developed an abscess. Her doctor would come in every day and put a probe in the wound. This, she recalled, was one of the most painful experiences of her life. "Every time you ask me a question," she continued, "you put that probe in again, and I can't stand it." Could she stand being given orders, I inquired. "Order me all you want to," she said. From that day on, instead of asking her questions, I issued orders. That eventually solved the problem.

On the other hand, when I give orders to other patients, some of them get angry and accuse me of attacking them. Apparently, what matters is not whether one asks a question or issues an order, but precisely what that communication suggests to the patient—how it is perceived. This distinction seems to be difficult for students in the field to comprehend.

A communication that one person experiences as hostile may be experienced by another as loving. In a group situation, for example, a man turned to a woman member and said, "Gee, you are a very warm, lovely person." Then he laughed. She retorted angrily, "You're a miserable creature to talk to me that way." He asked, "What did I do to offend you? I felt I was just complimenting you." She said, "I experienced that remark as condescending and humiliating." Two other women in the group agreed with her.

In his executive capacity, this man is accustomed to giving orders that people are usually pleased to follow. But when he gives orders to his wife, she reacts as some of the women reacted in that group session. She became enraged when he told her, "You damn well better get pregnant because I want a child." He thought that any woman given that order would feel complimented and honored; it did not occur to him that some would regard it as sexist in nature.

The point I am making is that *aggression is in the eyes of the beholder*. One has to learn that it is not the intent of a communication but its effect upon the patient that is decisive. A physician may give a patient a hypodermic to save his life, but the patient may regard the injection as an aggressive act because he experiences it as painful. In psychological medicine, the therapist's tone of voice and

the climate in which an intervention is made are important factors in determining whether it will be perceived as attacking and humiliating or as considerate and kind.

The schizophrenic patient suffers from *unchannelized* aggression (in addition to emotional deprivation). He needs an extensive course of training to enable him to express his aggressive impulses in language. He learns very slowly; the training may take five or ten years, and at times the analyst becomes infuriated at him. If these feelings become too intense, the analyst may go into a countertransference psychosis or obsessional pattern, or may experience a psychosomatic reaction such as hypertension. In the throes of some reaction that robs him of his therapeutic usefulness to the patient, the analyst has the

choice of resolving the problem, either through self-analysis or the help of a fellow-practitioner, or of discharging the patient.

Frieda Fromm-Reichmann stated many years ago that "if and when" it seems impossible to establish a workable relationship with a schizophrenic patient, "it is due to the doctor's personality difficulties, not to the patient's psychopathology" **(1952)**. The contemporary literature has reflected more and more awareness of the fact that successful treatment of the schizophrenic patient depends in large measure on the personality of the therapist and his self-analytic ability.

The requirement that the therapist himself undergo analysis was imposed as one of various approaches to the solution of the problem under discussion. The personal analysis does not necessarily mean, however, that the practitioner will be able to synchronize his emotions with the patients' emotions. Nor does the personal analysis always equip the practitioner with the ability to disengage himself emotionally from the patient and to respond to the patient in such a way that the treatment relationship will progress rather than stagnate, bogged down in treatment-destructive resistance.

As a result of working with the schizophrenic patient, we have come to recognize that the effects of the patient's emotions on the analyst and the analyst's emotions on the patient are complex. Sometimes their emotions need to be synchronized and sometimes they need to be de-synchronized.

The therapeutic implications of the combined emotional states of the analytic partners have frequently been observed. An outstanding

example is the situation in which, in a state of emotional synchronization, analyst and patient both feel that the patient is on the road to recovery, and this turns out to be correct.

Theoretically we could say that the contours of this development are clear. In other words, it occurs when the analyst works to resolve transference resistance and to resolve the counter phenomenon—countertransference resistance. But what the emotional dynamics of this development are—how the emotions of the partners mesh, how they separate, and how they change—is beyond the scope of our present knowledge. In the years ahead, we will have to develop a whole new science of emotional interchange.

The schizophrenic patient requires a highly specific emotional input from the analyst; the analyst working with him needs a highly specific input from the patient. The emotional inputs that are required can be provided by the therapeutic dyad, by the group team **(Spotnitz, 1980)**, or by some combination of both settings. A science of emotional interchange would facilitate the recognition and mastery of the successive steps needed for the maturation of the schizophrenic patient.

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