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The Silent Revolution in Psychoanalysis: Hyman Spotnitz and the Reversibility of Schizophrenia

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Based on an interview with Hyman Spotnitz in 1998 as well as his published work, this paper traces the development and formulation of Spotnitz's ideas regarding schizophrenia and the narcissitic transference-countertransference. The author proposes that Spotnitz's discoveries and treatment approach and techniques represent a new paradigm in psychoanalysis.

Any new interpretation of nature, whether a discovery or a theory, emerges first in the mind of one or a few individuals. It is they who first learn to see science and the world differently, and their ability to make the transition is facilitated by two circumstances that are not common to most other members of their profession. Invariably their attention has been intensely concentrated upon the crisis-provoking problems; usually, in addition, they are men so young or so new to the crisis-ridden field that practice has committed them less deeply than most of their contemporaries to the world view and rules determined by the old paradigm.

Thomas Kuhn, *The Structure of Scientific Revolutions*

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In December 1997, more than 500 psychoanalysts and students from around the country gathered for a conference in Manhattan that featured a videotaped interview with Hyman Spotnitz, the remarkable nonagenarian who discovered, as long ago as 1940, that the schizophrenic process was reversible by the psychoanalytic method. In the interview, conducted by Phyllis Meadow, Spotnitz discussed his latest paper as well as many aspects of his pioneering work.

Spotnitz's Early Work: Narcissistic Transference-Countertransference

On the locked wards of New York State Psychiatric Institute in the early 1940s, after a great deal of experimental work with insulin treatment, drugs, and electroshock treatment, Spotnitz, then a resident psychiatrist and research worker, found that Freud's talking cure could be applied successfully to repair and heal the most severely fractured minds. He realized that the basic problem in schizophrenia was an excessive quantity of destructive aggression unleashed against the mind. This new understanding of the etiology of the disease led to the development of an arsenal of new interventions aimed at resolving the most intractable problems. By the late sixties Spotnitz had fully conceptualized his operational theory of the treatment of schizophrenia. Published in 1969 as *Modern Psychoanalysis of the Schizophrenic Patient*, it is the only systematic theory of technique for the treatment of severe emotional disorders. In it Spotnitz schematizes the range of interventions required in order to help the patient move from a “rudimentary to cooperative relationship.” From the patient's first visit to issues of termination, through abundant case material and verbatim dialogue, Spotnitz explains the method and illustrates the rationale for working with what he calls “preoedipal” problems. The book contains profound implications for the efficacy of the psychoanalytic method. In the revised version of 1985, Spotnitz writes,

> *As far as we know no one is born schizophrenic; the hereditary factor appears to be a biologically inherited disposition for the disorder—a predisposition of some importance, combined with experiential and constitutional factors. Cases that appear to have been primarily determined by life experience are regarded as the easiest to reverse. Regardless of etiology, however, there is no evidence that the condition is not completely reversible. (p. 17)*

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The audience at the conference, many of whom had been trained by Spotnitz or by other analysts in modern psychoanalytic training institutes, often rocked with laughter during the video in response to his powerful anecdotal style:

> *One woman came to the office with a large bag in her hand. She took out a knife. “Are you afraid of me?” she asked. “I certainly am,” I said. “Good, then I won't have to kill you,” she claimed. The trick is, to figure out what to say to the*

patient so that they won't kill you.

In a sense, this says it all. Spotnitz discovered that an enormous quantity of what is called "unbound" destructive aggression, ricocheting around the mental arena, threatening to overwhelm the ego, was at the core of the schizophrenic dilemma. In order not to go out of control and commit murder or suicide, the patient destroys his own mind, and the result is the puzzling configuration of miscommunication experienced by anyone trying to communicate with the person. The positive elements in the personality are completely consumed in the attempt to keep these powerful forces in check. It's as though the schizophrenic mind is encapsulated, trapped in a repetitive cycle of dreamlike images and torturous existence, apparently impervious to outside influences. In the analysis, the patient needs to feel safe enough to be able to discharge this bottled-up rage toward the analyst. Doing so frees the positive elements in the personality for growth. In order to accomplish this, however, the analyst has to be willing to enter into a fully emotional relationship in the transference and to be the target for this explosive rage. The analyst must step out of the role of the benign helper and enter a world filled with terror, confusion, rage, and emptiness in order to establish contact and communicate in such a way that the patient becomes able to resume his psychic development. These are the ideas that jolted the psychoanalytic world of the 1940s and aroused opposition.

How did Spotnitz come to make these discoveries and what was it like when he first tried to present them to his supervisors and colleagues? I had heard only the modern psychoanalytic legend that he had been "thrown out" of New York Psychoanalytic for "claiming to treat schizophrenia psychoanalytically." I wanted to interview Spotnitz and hoped he would tell me more about this. I called him up, and he agreed to the interview, which took place over the phone. I began by asking what had led him to his research.

A chemistry major in Harvard's class of 1929, Spotnitz sailed for Europe to attend medical school in Berlin, committed to a career in research. Cancer and schizophrenia were the major unsolved problems

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of the day. On the voyage he read in the *Times* that Rockefeller had just given a million dollars for research on diseases of the nervous system to the Kaiser Wilhelm Institute for Brain Research at the University of Berlin. He asked the director if he could study there, and was invited to work with Max Fischer, the Nobel Laureate in visual distance research. Freud was not studied formally in the medical curriculum, but Spotnitz and his friend Mark Kanzer read his work and began to experiment with self-analysis. Freud's prevalent idea at the time was that the patient goes into analysis to achieve self-knowledge, which then gives him the option to change. In other words, the analyst is the agent of cognitive information about the self, but is not trying to change the patient. When Spotnitz returned to the United States in 1934, he spent two years at the Neurology Institute of New York doing a residency in neurology and psychiatry. After that he spent a year at the New York State Psychiatric Institute and began doing research with Charles A. Elsberg, professor of neurological surgery at Columbia, got his doctorate in medical science at Columbia, and wrote many papers about neurology. "At the time," he told me, "they were having a lot of success with ambulatory insulin treatment in reversing psychotic reactions. But when the drug was removed, the pathology returned. Electroshock treatment was also being experimented with a great deal." Spotnitz said that it was at this time that he studied Freud quite intensively to try to find out why he had failed with schizophrenia. **Freud (1917)** had given up when he hit the "wall of narcissism," the purely negative patient who had no interest in relating to him. He dismissed many cases as unfit for analysis. Spotnitz tried to do everything Freud had done, even smoking seven cigars a day, trying to recapture Freud's mind-set. He learned that Freud couldn't work with psychosis because, Spotnitz said, "He hated psychotics, the psychosis in himself. If you're going to work with psychosis, you have to be in touch with your own psychosis and be willing to 'be psychotic' with the patient in the session." Spotnitz came to believe that the constant cigar smoking was one of Freud's defenses against psychosis, and also that it ultimately led to his death from cancer of the jaw.

I asked Spotnitz what made him so optimistic about psychoanalysis that he imitated Freud so extensively. He said he wasn't particularly hopeful, but that he was interested in trying everything. He continued,

It was purely empirical, the full-push approach. We were willing to try anything. But we found out that only talking worked. There was a patient who had come in with a diagnosis of anxiety hysteria, which was then changed to manic-depressive psychosis, and finally to catatonic schizophrenia, which is when I got her, because they knew I was interested in

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schizophrenia. Her parents had been epileptic and schizophrenic. 1 learned that she had had an abortion and become psychotic. I worked with her several hours a day, seven days a week. She told me everything and was cured. It took about six months.

"Just by asking her questions?" I asked.

"She had hated her husband for forcing her to have sex. She relived it in the transference and recovered. I used the thoughts and feelings I had about her. She hated me. One time she threw an ashtray at me and barely missed me. I asked her how come she missed. 'I like you too much to kill you,' she said." Spotnitz chuckled. "Just like Anna O. If you say everything, it works."

In the 1997 Meadow interview, Spotnitz had also repeatedly stressed the importance of helping the patient to say everything: "If the symptom persists, there is something that hasn't been said, something still unconscious manifesting itself as the symptom."

Spotnitz is fond of referring to the case of Anna O., a young woman supposedly suffering from hysteria, who was treated by Freud's colleague Joseph Breuer from 1880 to 1882. Her severe hysterical symptoms (paralysis of the limbs, disturbances of vision, inability to eat, rapid changes of mood, feelings of having two selves) began to disappear as she talked to Breuer about them. She called the process "the talking cure," or "chimney sweeping." However, as Freud writes in 1932:

> *[O]n the evening of the day when all her symptoms had been disposed of, he [Breuer] was summoned to the patient again, found her confused and writhing in abdominal cramps. Asked what was wrong with her, she replied, "Now Dr. B.'s child is coming!" (E. L. Freud, **1960**, p. 413)*

Unable to comprehend what his patient was telling him, Breuer, "seized by conventional horror," as Freud puts it, "took flight and abandoned his patient to a colleague" (E. L. Freud, **1960**, p. 413). Commenting on the Anna O. case, Spotnitz said,

> *Breuer destroyed the field by fleeing from Anna O.'s pseudopregnancy. Freud rescued it by calling the experience transference. If he had taken the countertransference and used it with schizophrenia, he would have eradicated it. It's the countertransference that helps you treat the schizophrenic patient.*

Spotnitz contends that Breuer's and Freud's inability to recognize the powerful countertransference aroused in the case, which resulted in Breuer's flight from Anna O.'s pseudo-pregnancy to go off on vacation

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with his wife, delayed Freud's reporting of the countertransference phenomenon by almost 30 years. When **Freud (1910)** finally did recognize it and write about it, he thought that it was an "object" type of transference (coming from feelings a person had about people in his past) and recommended that it be "overcome," that practitioners do whatever possible to stifle feelings that might interfere with the analysis (pp. **144-145**).

In a paper written in 1984, Spotnitz notes that his first case at the Psychiatric Institute bore similarities to the case of Anna O. Both Spotnitz's patient and Anna O. were charming women in their early twenties. There were sexual issues and questions about diagnosis in each case. Describing his case, Spotnitz **(Rosenbaum & Muroff, 1984)** writes,

> *In my case, I became aware of feelings for this attractive young woman and sensed a desire to make her pregnant. At that very time she began to talk about the circumstances surrounding her breakdown. In the light of our present understanding, I would say that she transferred her desires to conceive a child, inducing similar desires in me. In the context of this narcissistic transference-countertransference situation, she was reliving her feelings for her husband. She said that she had become psychotic as a result of having sexual relations with her husband when they were practicing coitus interruptus and he failed to withdraw successfully. At her insistence they had agreed to wait a year before having a child, and her husband told me that he had no intention of making her pregnant against her wishes. She said, "That bastard husband of mine was really trying to make me pregnant. That was not a mistake. It was intentional, his idea of tricking me." Then, out of guilt, suppressed rage, and remorse, she became psychotic.*
>
> *As the patient continued to verbalize her feelings, she came to recognize that despite her conscious resolve to put off raising a family, she unconsciously wanted to become pregnant and had apparently induced that desire in her husband. As soon as she understood the situation, she demonstrated that she really wanted to have a child. Our warm relationship terminated in her wish to return to her husband and have several children with him. (pp. 133-134)*

Spotnitz treated this case at the New York Psychiatric Hospital in 1940. He witnessed the reversal of the psychotic process in this young woman as she became able to verbalize her thoughts and feelings directly to him. This was the beginning of his journey into the psychoanalysis of psychosis. It took Spotnitz until 1969 to fully operationalize his ideas into a systematic theory of technique, but undoubtedly the single most important discovery he made, perhaps the one that resulted in his leaving the rest of the field behind, was that there was a second kind of transference and countertransference. The person whose problems

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originate in the preoedipal, which is also the preverbal, period of development, before there are distinct boundaries between the self and the other, will form what is called a narcissistic transference and treat the analyst as part of the self. At this level of ego development, there are different kinds of psychic states, but they all have a quality of totality. Whatever the nature of the perception, the analyst actually *is* what is perceived. In other words, he is not just *like* someone; he *is* that someone, or that nothing. The patient may experience a great deal of fragmentation, and the image of the analyst may change from moment to moment. Or if there is the beginning of a "me" and a "not me," the analyst may be either a totally foreign and supreme being or a dangerous terrorist. Or this image may oscillate. In any case, the analyst needs to accept this perception in an uncritical way and not challenge it until the patient is able to "reclaim" it. For the analyst in this narcissistic or preoedipal countertransference state, feelings induced by the patient become fused with his own feelings and seem to him to be entirely unrelated to the patient, making the source of the feelings very

difficult to identify. For example, the patient may feel that the analyst does not really exist. In response, the analyst may feel indifferent or have no feeling for the patient and chastise himself for his heartlessness.

Spotnitz told me he first became aware of this phenomenon one day when he noticed that his right arm was moving a little and saw that the patient's right arm was also moving. Then he noticed the same movement in the patient's left arm. He began to realize that there was an unconscious oneness with the patient although he was consciously feeling unrelated.

In the narcissistic transference, patients also, as Spotnitz **(Rosenbaum & Muroff, 1984)** points out, "tend to transfer the aggressive feelings they experienced with their parents, and they tend to experience in the other person the aggressive feelings their parents had for them" (p. 135). As the early ego is developing, a prime mechanism for ridding the self of unpleasant feelings is to externalize them, i.e., to push them into the object field of the mind. In the narcissistic transference, the analyst eventually literally becomes this noxious part of the self: Hitler, the CIA, the impossible critic, or the constant judge. As Spotnitz puts it,

These patients need to be convinced that, no matter how you feel, you are not going to act on your feelings. The key to the effective treatment of schizophrenic, borderline, and seemingly hysterical patients like Anna O. is, in my experience, an understanding of the feelings induced by the patient and the ability to distinguish them from one's own feelings, combined with the ability not to act on them. (p. 135)

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The discovery of the crucial role of aggression and of the analyst's need to be aware of and to make use of his countertransference feelings were key insights, leading to Spotnitz's realization that it might be possible to reverse the schizophrenic reaction. Freud and Breuer had stumbled on the fact that verbalizing everything led to symptom removal, but they failed to recognize that the powerful feelings induced in the analyst were narcissistic counterransference reactions. Why was Breuer unable to recognize that he had feelings for Anna O. that may have been impairing his ability to treat her successfully? "It is quite clear," Spot-nitz **(Rosenbaum & Muroff, 1984)** writes,

that in the dawning years of psychoanalysis it was considered improper for an analyst to have countertransference feelings for a patient, just as parents were not supposed to have incestuous feelings or murderous feelings toward their offspring. For an analyst to sustain and admit that he experienced such feelings for a patient would have been regarded as shameful. Thus the analyst's need for self-approval and social approval may have retarded progress in facing the problems implicit in the countertransference. It is my impression, however, that unless you have real feelings for the preoedipal patient, unless you're aware of these feelings, and unless you engage in emotional communication with the patient, it is virtually impossible to help the patient appease his maturational needs and become an emotionally mature individual, (p. 139)

"Why are we so terrified of the feelings we tend to experience when we work with such patients?" I asked.

Spotnitz replied,

Because the feelings aroused in us by patients like Anna O. are of such a primitive nature that they threaten the foundations of our personality structure. We are willing at times to have positive feelings for our patients; what are particularly intolerable, and much disapproved of, are hostile feelings. We do not wish to experience such reactions to the emotionally disturbed individuals who need our help, and whom we are dedicated to helping. When we do get such emotions, we try to rationalize them. Sooner or later, however, we may get to feel that a patient ought to be put out of his misery and advocate euthanasia. Beginning analysts often want to get rid of the patient in one way or another. They will want to hospitalize or refer them. This is because they are not able to sustain the unbearable feelings of hopelessness they are having. They don't realize that these are induced from the narcissistic state of the patient.

Spotnitz thinks the horrible maltreatment of the mentally ill throughout history stems in part from these unrecognized induced feelings.

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One of the hallmarks of schizophrenia is to induce in the caretaker the desire to get rid of the patient. The patient may have absorbed murderous feelings from his caretaker early in life and have been unable to cope with them, or he may have generated murderous feelings internally. The child is too vulnerable to be able to tolerate these feelings. He can't know he is hated, and he can't hate back, so the only alternative is to go into a state of self-blame or self-destruction or deadness. Spotnitz calls this the narcissistic defense, the relentless insistence on blaming the self rather than the important parent/caretaker. Even in cases of paranoia, when the patient is feeling mistreated by and therefore blaming the object, the ultimate victim is the self. The natural response of the current "caretaker" to this extremely frustrating and heartbreaking state of affairs is to want to fix it or get rid of it, rather than to tolerate the hopelessness and the murderous feelings. Breuer hadn't been able to recognize that the shocking feelings he was having were emanating from the dynamics of the case. The recognition of the necessity for the analyst to recognize, tolerate, and use these feelings to help the patient was Spotnitz's first major step in successfully treating schizophrenia.

New York Psychoanalytic Institute

In 1939 Spotnitz was admitted to the New York Psychoanalytic Institute. He went into analysis with Lillian Delger Powers, vice president of the Institute, whom Spotnitz credits with helping him develop modern psychoanalysis. His supervisors were the leading analysts of the day: Sandor Rado, Sandor Lorand, Herman Nunberg, Sara Bonnett. He told me,

> *I was having a lot of success with schizophrenia in my practice. I was beginning to systematize what I was discovering. My success was not an idiosyncratic phenomenon, nor was it a result of a therapeutic personality, but they wouldn't listen to me. In those days, you brought in your own cases for supervision. I presented the case of the catatonic woman and they wouldn't listen to me. "That kind of case is unsuitable for analysis," they said. Nunberg said I was doing good work with her, but it was not psychoanalysis.*

By 1939 certain practices that originally were empirical explorations of Freud's such as the use of interpretation, five- or six-times-a-week sessions, and the use of the couch had become the inviolable tenets by

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which psychoanalysis was defined. Chief among them was that interpretation was the only acceptable method of intervening with a patient. Commenting on this, Spotnitz said,

> *When I reported that the patient was responding to interpretation, the case was acceptable, but when I reported that I had to use an emotional intervention, they said no, not suitable for analysis. For example, with the catatonic woman, after trying other interventions, I said to her that she wanted everything her own way. She got very angry with me. This was very helpful to her. But whenever I reported that the patient had gotten better, my supervisors said that the diagnosis must have been wrong. I was naive about the reception I was getting. I was already training others.*
>
> *Not everyone was on the couch, or coming five times a week. I finally realized that the analysts found this a big threat to their privileged position. They wanted to keep psychoanalysis pure, a monopoly. I was willing to train anyone. I was interested in curing patients with whatever technique worked. I was not interested in going through the motions just to be an analyst. A neurologist friend of mine sent me a woman suffering from grand mal epilepsy. Her husband was a painter. She worked in a department store. She was tired at night and slept through sex. She would awaken in the morning and have a seizure. I told her to have sex when she was awake and enjoy it, or not to have sex. She stopped having seizures. I was interested in curing people. I was a heretic.*
>
> *Here's another example of the resistance to helping these people. We were treating ambulatory schizophrenics at Brooklyn State Hospital with insulin, which reversed the symptoms and allowed them to go home. We needed the family's permission. They refused. It was OK if they died, but they didn't want them to come home. There was no room for them at home, they said. Eventually I left the New York Psychoanalytic. It was by mutual agreement. I went to the Jewish Board of Guardians and began training social workers. We did a great deal of research with groups of borderline and schizophrenic patients, and when we presented the results, we were told that the diagnosis must have been wrong. We couldn't use patient testimony because they couldn't admit to having a serious mental illness or they would lose their jobs.*

"There is always resistance to anything new," said Spotnitz, "and the more effective it is, the more resistance." He cited the opposition to smallpox and polio vaccines, all the arguments against flu shots, against inoculating children, against vaccines for lyme disease or tertiary syphilis, and he said, "You can ordinarily tell how good an idea is by the strength of the opposition. The new technologies will help document the changes in the brain brought about by successful talk treatment. For example, encephalography traces the hormones in the brain

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and how the various diseases affect them. Chemicals can change the structure of the brain, as can talk."

"Dr. Spotnitz," I asked, "brain structure is not the same as psychic structure, right?"

"Right," he replied.

"Do you think a day will come when changing brain structure will be able to correct the problems in psychic structure without talk?"

"It may be able to," he said. "Chemical treatment is helpful now. It's just that it doesn't cure the problem."

A New Paradigm

In *The Structure of Scientific Revolutions*, Thomas **Kuhn (1970)** posits that scientific revolutions do not derive from the linear accumulation of knowledge, but rather that they occur in response to problems or to anomalies that the old models are inadequate to

account for. “Scientific revolutions are those non-cumulative developmental episodes in which an older paradigm is replaced in whole or in part by an incompatible new one,” wrote Kuhn (p. 92).

Freud (1917) states that, “In the narcissistic neuroses the resistance is unconquerable; at the most, we are able to cast an inquisitive glance over the top of the wall” (p. **439**). In the same paper, he concludes that “sufferers from dementia praecox remain on the whole unaffected and proof against psycho-analytic therapy” (p. **439**). “Freud's views about the inaccessibility of these patients to psychological influence led to an unjustifiable constriction of the whole field of psychoanalytic therapy,” said Spotnitz.

Spotnitz began his pioneering work where Freud left off, with the patients who seem unable to form any relationship at all with the analyst, the patients who seem endlessly negative or oppositional, the patients whom Freud rejected as unfit for analysis. He discovered the mechanisms of mental functioning at these levels of development that had not been understood before. This new knowledge helped clarify the core underlying dynamics in any personality, and the new techniques that worked with schizophrenia were also applicable in any analysis when the patient was functioning at a preverbal level. The discovery of the reversibility of schizophrenia paved the way for making psychoanalysis more effective for everyone. As **Kuhn (1970)** points out, a revolution requires or has ramifications for the entire field.

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Freud's dual drive, or instinct, theory was adequate to explain the problem of an excess of destructive aggression in the personality. It claims that we are fundamentally biological creatures, moved in both positive and negative directions by forces we're not always in control of. But his primary technique, interpretation, basically a cognitive method, hadn't kept pace with his theoretical developments. This was, in effect, what **Kuhn (1970)** would refer to as a crisis in the field that called for a new paradigm. The old model of interpreting the unconscious defenses and analyzing the ego was inadequate to cope with preoedipal problems that had developed before the acquisition of language.

It makes sense that a cognitive technique would not be adequate to affect an early emotional state. Preoedipal, or preverbal, problems have to do with the vicissitudes of impulses during the earliest formation of the ego, not with conflicts between people. One of the first tasks in the development of the mind is to get rid of tension and discomfort by ejecting what doesn't feel good onto what is perceived as the environment. At this stage there is not enough ego to contain both positive and negative impulses at the same time. The infant is either comfortable or uncomfortable; there is as yet no complexity or subtle differentiation of emotion. What this situation looks like in an adult fixated at this level is either a great deal of confusion or a clear perception of the negative image as “out there” in the universe, i.e., the object field of the mind.

In the new paradigm of the narcissistic transference-countertransference matrix, the analyst becomes this externalized version of the self, thus relieving the patient's fragile ego of pressure until, by putting his feelings into words, he has created an ego strong enough to be able to “egotize” this image, to reclaim his own negative aspect. While a person is in this state, there is no part of the self left to observe this process, no awareness that this perception is “crazy.” The person who is consumed with this task, of organizing his experience around the “location” of these states of discomfort, has very little conscious ego left with which to relate to other people or to the world. When later the patient is in the process of integrating his ego, he will become aware of parts of himself that had seemed totally foreign to him when he was trapped in the earlier state. This explains why the therapeutic alliance, one of the cornerstones of classical psychoanalytic technique, cannot be effective in dealing with a patient with preoedipal problems: there is simply no ego there to ally with the analyst. There is only the analyst as the receptacle for the unwanted parts of the self and the patient's perceived self. If the analyst tries to be an ally in this state, it will force the patient into deeper states of depression, or exacerbate an already explosive

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situation. The analyst must squarely encounter the destructive forces in the patient in order to help him verbalize them.

Edelman (1992) in *Bright Air, Brilliant Fire* provides a fascinating corroboration of this process from the point of view of neuroscience. He describes two kinds of consciousness, primary consciousness and higher order consciousness. Primary consciousness, a state we share with certain animals, is limited to what he calls “the remembered present.” Certain perceptions necessary for survival are remembered automatically, stored in the vital memory bank for that specific species. In this state there is consciousness but no sense of time and no ability to predict or plan for the future. “Higher order consciousness arises with the evolutionary onset of semantic capabilities … it depends on building a self through *affective subjective interchanges.* … The result is a model of a world rather than of an econiche, along with models of the past, present, and future” (p. 150, italics added). It is striking. when working with schizophrenia, to witness the patient's emergence from the frozen state into a world with a past, present, and future, into life.

New techniques are required for this task, ones which supply the “affective interchanges” needed to bring these competing emotional states to the level of language and create a strong ego. The analyst needs new methods—emotional and symbolic communication, joining and reflecting—and these new methods are components of what **Kuhn (1970)** would call the new paradigm within the field. The new paradigm, Kuhn states, “is not simply an increment to what is already known … [rather] its assimilation

requires the reconstruction of prior theory and the re-evaluation of prior fact, an intrinsically revolutionary process that is seldom completed by a single man, and never overnight" (p. 7). "Ordinarily" says Kuhn, "the new paradigm attracts an enduring group of adherents away from competing modes of scientific activity … and is sufficiently open-ended to leave all sorts of problems for the redefined group of practitioners to resolve" (p. 94). The women and men whom Spotnitz trained constitute this cadre of individuals who have founded institutes and have written numerous books and papers, presenting voluminous clinical data and pursuing important research. Many, from the first generation, began their careers in psychiatry, social work, or psychology, entered analytic training, and then found their way to Spotnitz or a colleague of his when they needed help with a particularly difficult case. By the 1970s they had founded five modern psychoanalytic institutes, all of which were open to training people from all walks of life, in the European tradition. This generation founded the journal *Modern Psychoanalysis* and

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trained the analysts who are now treating a full spectrum of emotional problems psychoanalytically.

The Maturational Model

Once the nuclear conflict in schizophrenia was defined and the necessity for emotional interventions established, other important dimensions of psychoanalytic treatment needed redefinition. The definition of cure, the role of the analyst, and the techniques required all needed to be reformulated. Freud did not conceive of cure as simply the disappearance of symptoms or the attainment of normality in functioning and behavior, rather he thought that the individual who is successfully analyzed is "permanently changed, is raised to a high level of development and remains protected against fresh possibilities of falling ill" (**1917**, p. **451**). Spotnitz concurs with this goal and, unlike Freud, maintains that this is possible for patients with schizophrenia. However, Spotnitz conceives of the process of cure along the lines of a maturational model rather than the original causal one that depends on insight. With the discovery of the narcissistic transference-countertransference matrix, it became clear that fixations at these preverbal levels were resistances, not to knowledge, but to emotional learning and unlearning. The challenge is how to help someone who can only feel persecuted, who can only accuse or confuse, say new words and have new experiences that facilitate new mental connections.

In chapter four of *Modern Psychoanalysis of the Schizophrenic Patient*, "A Neurobiological Approach to Communication," Spotnitz (1985) describes how psychoanalysis influences the functioning of the central nervous system and how changes in the central nervous system influence verbal communication. He claims that the individual will reach his growth potential unless the environment lacks critical ingredients or exposes him to forces that militate against his behaving as his growth impulses dictate. There is, in other words, an inherent drive toward life, toward the full maturation of the personality. If, however, the post-uterine environment fails to provide the series of interchanges conducive to growth, the ensuing "maladaptive patterning" of the personality will form a "spectrum of functional disorders, ranging from mild forms of psychoneurosis to psychotic conditions" (p. 84). What needs to occur in the analysis is a series of verbal interchanges with the analyst that accomplishes a re-patterning of these pathways in order to

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create the highly functioning nervous system typical of a mature individual. "Words from the analyst are highly specific psychological medicine and tools for producing changes in the nervous system" (p. 80). "Treatment is no longer defined by etiology. The cause [of the problem] can be biological and genetic and/or environmental and psychological and still be altered by psychological means" (p. 34).

As the evolutionary biologist E. O. **Wilson (1998)** explains in an article outlining his argument for the biological bases of morality, "the essential ingredient for the molding of the instincts during genetic evolution in any species is intelligence high enough to judge and manipulate the tension generated by the dynamism between cooperation and defection" (p. 62). This "intelligence" is what the analysts would call ego, an agency strong enough to keep the forces of defection in check. This tendency toward defection Spotnitz, like Freud, calls the aggressive drive, which, if not under the control of libido, or life drive, operates to fragment the personality and sever the ties with people. Pathology results when there is an excess of unbound aggression in the personality that ends up directed against the self. In other words, in schizophrenia, as in other self-destructive modes, hate is paralyzing the capacity to grow. Thus, the goal of the treatment becomes liberation of the personality from the destructive grip of the aggressive drive, leading to the maturation of the individual. No longer is cure defined in terms of insight and reconstruction of the past. Those may occur during growth, said Spotnitz, but they are not required for it. Classical psychoanalytic treatment, using the cognitive/causal model, offers Freud's "transformation of neurotic suffering into ordinary misery." "The classical analyst does not want to change the patient in any way. The modern analyst wants to change the patient, to help him develop his full potential," Spotnitz explained.

From the initial agreement when fee and frequency of sessions are determined to questions about how and when to terminate the treatment, the patient's wishes direct and illuminate the process. Spotnitz said:

> *I always want to know what the person wants to achieve in the analysis…. Some people know and some don't and some change their goals in the course of the treatment. I direct the analysis toward achieving the goals of the patient by trying to find out what their resistances are to achieving these goals and how these resistances toward their life goals become*

resistances toward the analysis, so I can analyze these transference resistances and help the patients achieve their goals.

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Every step of the way, moment to moment in each session, the analyst works to help the patient verbalize these resistances, and as they are verbalized, the symptoms disappear, and the goals become realizable. This sounds smooth and achievable until one remembers the complexity of the notion of goals. Some people want to get married and have babies. Some want to feel more vital. Some want a spouse to behave better. But some people have no goals that they are aware of. Some come into treatment just wanting to suffer less. The schizophrenic patient is trying very hard not to go out of control and has very little energy available for pursuing constructive goals. At that level of functioning, the analyst must support the patient's operating defenses, i.e., he must protect the preverbal ego because the patient lacks the ego strength to contain his own impulses.

There is a deep paradox in the practice of modern psychoanalysis. The cause of the pathology is conceptualized as aggression turned against the mind or the body, and the solution is the verbalization of this aggression in the transference, but the patient needs to experience some affection before this can occur. As Spotnitz explained in an interview for his eightieth-birthday *Festschrift*,

> *People can't express rage unless they have affection … they need to feel safe, to feel loved, to feel secure. When children are neglected they want to spite their parents by holding back their bowel movements. If they don't get enough affection from the people around them, they don't want to express their rage and anger—they keep it in, and it produces psychosomatic illness, or schizophrenia, or depression. (Sheftel, **1991**, p. 38)*

The techniques that Spotnitz devised—joining, mirroring, reflecting, asking object-oriented questions—are designed to protect and insulate the preverbal ego until it is strong enough to translate impulse into thought and feeling and then thought and feeling into words. These techniques establish the analyst as an object like the patient, a comforting idea and one that communicates affection. Gradually the patient becomes able to put more thoughts and feelings into words and to emerge from the regression.

Case Example

Near the end of my interview, Spotnitz asked me if I had any cases that I was having a problem with. He said that the essence of what he had

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been talking about was narcissistic countertransference and that it is best understood through cases. I certainly did have such a case and presented a situation that had me completely stymied.

Many years ago I began working with a young woman who had been diagnosed manic-depressive and was taking heavy doses of antipsychotic medication. She was very sociable, liked being with people, but often had difficulty establishing an intimate relationship. Last year she became quite serious about a man, began having sex, and was soon becoming more and more depressed. She went to her psychopharmacologist and complained of the depression. Apparently, the doctor told her that the latest medications should be able to help her more than her old tried-and-true drug, but she would have to go off of it for three weeks in order to get it out of her system. She did so and immediately went into a terrible tailspin and became suicidal. I asked her if she needed to be hospitalized. She agreed that she did, was admitted to the hospital, and immediately stabilized. The hospital then gave her new medicaton and dismissed her as soon as her insurance ran out. And the scenario recurred. She regressed immediately and was admitted to another hospital, where the process was repeated. It was excruciating to sit through the sessions with such suffering. I tried every intervention I could think of, but nothing seemed to help. Her psychopharmacologist tried every new drug known to the psychiatric world, but she got worse. Finally she went into McLean Hospital, known in the Boston area as expert in prescribing medication. A week later I got a call from her psychiatrist at McLean telling me the only alternative left appeared to be shock treatment. I was horrified, but I felt so helpless that I began to wonder if shock therapy might help, and then I was horrified at myself for wondering. At this point I felt that my contact with her was extremely precarious.

I told Spotnitz all this, adding that all she did in the sessions was to complain about pain, incredible psychic pain, and that I was at a loss as to how to respond. He told me to tell her, “It's OK to suffer. It's OK to feel pain. Just keep talking.” Then he asked, “What does she want from you?”

“She wants me to say that everything is going to be all right,” I explained.

“So why don't you say it?” he replied.

“What! I can't say that!”

“Why not?” he asked.

“Because she's in such a negative state, it might make her more suicidal.”

“Patients have a right to resist,” said Spotnitz. “Say exactly what she asks you to say. No more, no less.”

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"What if she asks me if it's true?" I asked.

"What's true got to do with anything?" he said.

"I can't believe you're telling me to do this, to tell the patient what she wants to hear," I said.

"Why not," said Spotnitz, "any reasonable request, see if they improve."

In the next session, I followed his instructions exactly. The patient complained of terrible pain. "It's OK to feel pain," I assured her.

She said, "I'm out of contact with people. I can't stand it."

"It's OK to be out of contact. Just keep talking," I said.

She continued to talk about her pain and suffering and added, "I wish you would help."

"What would help?" I asked her.

"Tell me I'm going to get over this. I can get better."

"You can get over this. You can get better," I told her.

She laughed and replied, "You said just what I said. I wonder if you mean it. I think you do." She began to talk about some different issues.

In the next session she asked if she could cut her sessions from twice to once a week because she wanted to go to meditation therapy. This patient often engaged in other treatments, to which I had no objection. However, given her condition, I had been reluctant to agreeing to a reduction in the frequency of sessions. But remembering Spotnitz's statement about any reasonable request, I said, "Why not?" She was very relieved. She showed up for the next session with a new hairdo and in a significantly better mood. She told me she thought I wanted her to live. There were no more calls from McLean. After beginning a new job, she told me I had come a long way. She was right.

In this case it was clear that I was functioning as an omnipotent object who thought she knew best. I hadn't realized, however, that the "know-it-all" state was coming from the patient (that she had induced that feeling in me) and that I was locked into a know-it-all battle with her. We were both know-it-alls, and we were both helpless in the face of the illness. We both teetered between being totally powerful and totally helpless. Once I moved out of this position and began to "echo" her ego, the patient began to improve. The patient needed to feel that I was willing to do what she wanted, that she had the power to conjure up the object she needed. This put her on the path to recovery. We have a way to go before this woman is able to freely express her thoughts and feelings, but a major step was taken when I was helped to move out of the omnipotent/helpless position and resume analyzing her. As Spotnitz (1985) wrote, "the prognosis of an emotional disorder is significantly influenced by the capacity of those concerned with its treatment to treat

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it successfully … as this capacity develops, the prognosis improves" (pp. 34-35). The conviction that nothing can be done is a narcissistic countertransference feeling. In the case of this patient, most of the psychiatrists in Boston had been induced with this feeling.

Conclusion

Whether the problem is general malaise, depression, schizophrenia, or cancer, the goal of any modern psychoanalyst remains the same: to help the patient say whatever it is he needs to say in order to alleviate the symptom. "Whenever there is any piece of symptom left unconscious, the symptom persists…. We must study more how to help the patient to say everything, to say what he doesn't know, to say the unthinkable, without damaging him in any way," said Spotnitz. His ideas are echoed across the ocean by Miriam Szejer, a French Lacanian analyst who is doing pioneering psychoanalytic work with failing-to-thrive infants. "Suffering" says **Szejer (1999)**, "in its analytical sense, is to suffer in the work of speaking. Be it of body or soul, it is always symbolic suffering, and the need for speaking is so real that the body may be affected by it, in its organization, its functioning, and its integrity." "Ultimately," Spotnitz (1997) wrote, "when patients have been successful in 'saying everything' we hope that they will also be able to say sincerely and honestly that they are having a healthful, satisfying and happy life! That is the goal of analysis" (p. 40).

Whether Spotnitz's work is eventually absorbed by the classical psychoanalytic tradition, as he predicts, or continues as a separate branch of psychoanalysis remains to be seen. But his unflinching commitment to the well-being of his patients and his refusal to succumb to the temptations of power or the lures of prestige secures him a place in the finest tradition of the physician/scientist.

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