schizophrenic patient may be anti-social in his behavior, but actually he is a very social-minded human being. Too social-minded, in fact, for his own good. He unconsciously sacrifices his ego to preserve his object. What he has to learn is that both can survive.

To employ the concept of the narcissistic defense in teaching this lesson, the therapist must, so to speak, throw himself in the direct line of fire. He may expose himself to injurious action even as his self-preservative instincts are warning him that he would be better off if his treatment partner were shut up or locked up. The therapist may unconsciously tend to identify with his patient's anxiety about acting destructively if he permits himself to "blow his top." That is probably why we hear so much about the necessity of serving as a reassuring presence to reduce the patient's anxiety, or about helping him carry his hostility.

That is much safer for the therapist. But if carrying buried hostility is what made the patient ill, helping him to go on carrying it won't make him well. That is the predicament of the therapist who chooses to work as I do on the problem of frustration-aggression (Spotnitz, 1969a).

The Way Out

Reinforcement of the narcissistic defense as long as the patient needs its protection is the way out of this predicament. He has to be educated to feel the urge to destroy you—slowly educated, so that he will feel that urge comfortably enough to control his behavior. As he oscillates between positive and negative transference, his ability to control his actions is repeatedly put to the rest. The therapist does not work for the resolution of the narcissistic transference until he is certain that his patient can talk out his destructive impulses, not act on them. Teach him to *feel* like killing you, to *tell* you about it, and *not* to do it, I advise my students.

Meanwhile, he has to be provided with enough gratifying experiences over an extended period of time to change the feeling-tone of his communications. Ideas of disintegration and alienation usually dominate him when he enters treatment. An understanding relationship with a therapist who has a genuine interest in treating him, and feels comfortable in his presence, enables the schizophrenic patient to acquire a more positive orientation to his family and his society. But this kind of re-education is a time-consuming process. A minimum of five years is usually required to predispose him to accept the pain and suffering which the realities of his life may entail.

Major factors in the resolution of the narcissistic defense are the strengthening of the protective barrier against stimuli and the development of new action patterns for the healthful and productive discharge of impulsivity.

11

The Need for Insulation

The clinical approach to be explored and the concept of narcissistic defense (Chapter 10) are related aspects of a general theoretical framework for understanding the dynamic processes which operate in schizophrenia. This understanding, derived from experience with schizophrenic patients, appears to be of vital significance for their treatment.

In my discussion of the narcissistic defense, it was hypothesized that the excessive self-love and self-preoccupations of these patients serve as a cloak for self-hatred. Their pathologically narcissistic behavior is patterned very early in life into a primitive defense system against the discharge of high accumulations of mobilized frustration-aggression. The ego is sacrificed to prevent the release of destructive impulsivity in action that would injure the object.

The tendency of the schizophrenic patient to accumulate destructive impulsivity in his ego appears to be connected with two pathogenic situations: the historic failure of his infantile mental apparatus to acquire a good protective coating, and the under-development, or strangulation, of its discharge patterns. Abnormally weak barriers against the encroachment of external and internal stimuli force the schizophrenic ego to resort to unhealthful forms of protection against overstimulation; the insufficiency of self-protective action patterns, including verbal patterns, expose it to overwhelming types of discharge characteristic of the most sever psychotic states. Schizophrenia itself appears to be a pathological process of compensatory insulation that is set in train by these developmental circumstances.

CONCEPT OF PROTECTION

In a picturesque passage in "Beyond the Pleasure Principle," Freud (1920) calls attention to the need of the personality to be shielded against environmental forces that serve to interfere with its natural growth processes. He compares the living organism to a tiny vesicle "suspended in the middle of an external world" whose energies would overpower the vesicle if it did not possess a protective shield against this continuous bombardment. Freud writes: "*Protection against* stimuli is an almost more important function for the living organism than *reception* of stimuli. The protective shield is supplied with its own store of energy and must above all endeavor to preserve the special modes of transformation of energy operating in it against the effects threatened by the enormous energies at work in the external world—effects which tend towards a levelling out of them and hence towards destruction" (p. 27).

The notion of a protective coating against the dangerous impact of the environment may be rendered more clear through a brief incursion into the principles of electrodynamics. The term *insulation*, applied in its technical sense to the personality, suggests the dynamic processes by which the mind copes with pressures to prevent its energy systems from being overloaded.

The efficient operation of an electrical system testifies to the presence of so-called non-conducting materials between the energized elements of its circuit. These materials confine the current to the wires or other components of the circuit where it is designed to flow. The non-conductors would be more aptly referred to as poor conductors or as materials that are highly resistant to the flow of electric current, because they cannot prevent the current from flowing through other regions if the voltage gradient exceeds a certain point. If it does, what ensues is called a breakdown or puncture.

Justification for applying this concept to mental functioning comes from the science of electroencephalography. It has taught us that the brain operates like an electrical apparatus, generating those rhythmic electrical currents that we call brain waves. Alternating currents of variable frequency are produced by the billions of nerve cells in the brain, and these currents can be measured when a large enough number of the cells repeatedly fire together. Although we are still far from understanding the basic mechanics of this very intricate human apparatus, it has become clear that the nervous system receives, correlates, stores, and generates countless signals which apparently determine our behavior.

It is reasonable to assume that the brain, too, requires insulation for healthful functioning—that is, that there be present certain substances which are poor conductors or are highly resistant to electrical or emotional currents. In a sense, emotional currents are also electrical currents. The

neurophysiological investigations of Wilder Penfield (1959) and his associates at the Montreal Neurological Institute have demonstrated that electrical stimulation of certain areas of the brain mobilizes the recall of long forgotten experiences. Events stored beyond the voluntary reaches of memory were awakened in patients undergoing brain surgery when an electrode was applied to the temporal lobe. Instead of requesting a patient to recall past experiences, the neurosurgeon applies an electrical current. Obviously, he does not have any time to spend in overcoming psychological resistance. I doubt that this method will ever be introduced into psychotherapy.

Presumably, the more insulation the brain possesses, the greater its capacity to store energy, the waves of electricity in the brain. When its insulation is weak and the pressure for discharge of the energy—the voltage, so to speak—is very high, it may be incapable of confining the flow of the current to the regular pathways. Instead, a breakdown or puncture may occur, as in an epileptic seizure or the explosive outbursts of the schizophrenic with a full-blown psychosis. The same thing appears to take place in a diffuse way in schizophrenia generally. In other words, abnormally high voltage in the brain—that is, a great deal of emotional tension—can lead to a failure in insulation.

Of interest in this connection is the report of an intensive study of epileptics. The authors, a group of French investigators, present an electronic theory of the cause of epilepsy. They develop the hypothesis that the brain is a condenser which requires insulation, and that excessive discharges of electric current in the brain produce epilepsy. The seizures stopped when the abnormal electric currents were drained off (*World-Wide Abstracts of General Medicine, 1961*).

INADEQUACY OF PROTECTION

The transference relationship provides ample evidence of the schizophrenic's lack of insulation. His general oversensitivity to the impact of the environment, or to a specific aspect of it, is frequently observed. Testimony on this point, which I have drawn from my own cases and supervisory work, can doubtless be duplicated by others who work with schizophrenic patients.

Their extreme sensitivity to the unverbalized and even the unconscious pre-feelings of others is consistently noted. They may be so swept up in these "borrowed" feelings that they feel impelled to act on them. "I was so dominated by my mother's feelings that I never stopped to think about my own," a schizophrenic woman told me. "I ate or did not eat depending on how my mother felt about it. My own needs were of no interest to me."

Another woman complained of being lacerated by her husband's feelings of mild disapproval, even when he did not voice them. "I can sense when he

feels like scolding me," she said early in her treatment, "and I get panicky about it. I get to feel that I am falling apart."

Even the movements of others may be overstimulating to these people. It was amazing to observe how one man used to move his arm or change his position on the couch the moment I moved my arm or shifted my position in the chair behind him. It was impossible for him to see me doing it and, as far as I could tell, there was no way of his hearing or sensing that I was moving. Somehow, though, he seemed to become aware of my discomfort and invariably responded to it himself, and exactly as I did.

Another patient would say, "Don't talk. I can't stand the sound of your voice." Later he came to recognize that he had tried to numb himself as a child in order not to feel his parents' anger, which had the effect of persuading him that he was absolutely no good. He, too, had operated consistently in response to his parents' feelings. In the course of his treatment, he had to learn to distinguish the feelings of others from his own.

Some of these patients are unduly stimulated by their own feelings. A youth who had been in treatment a year ran out of the office in the middle of a session. A few minutes later, he rang the bell and returned. My silence had aroused feelings that he could not tolerate. To feel like committing some act they disapprove of implants fears in many schizophrenic patients that they will actually commit it. Mildly positive feelings for attractive women were a source of terror to one young man; it was his fear that such feelings would force him to "cheat" his steady girl friend. He said that he felt like an alley cat when he merely experienced a wish to date anyone else. This man had fought for years against becoming aware of his feelings. The only one he did not object to was elation, the feeling associated with his pleasurable contact with his mother.

Bodily sensations may also be fought, especially those that awaken memories connected with impulses to engage in destructive activity. To a man who had been sensitive to his mother's rough physical handling of him as a young child, sexual excitement was a source of torment. It evoked the recall of her painful punitive measures, thus giving rise to disagreeable fantasies. These fantasies, in turn, aroused strong impulses to obliterate the sensations by cutting off his genitals.

Some patients are hypersensitive to their own thoughts One of them referred to the prolonged silences he had required during the early phase of his treatment as periods of escape from ideas which occurred to him. The thought that business associates might watch him while he worked was very disturbing.

I treated a schizophrenic woman who lived in perpetual fear of killing her husband and young child. To read a news report of a murder or just to think about one put her under so much pressure to act out her urge to kill

that her control was threatened. Temporarily she eased this pressure by running off into fantasies of being judged insane and committed to a mental institution for life. So much panic was created by these fantasies that they became more threatening to her than the danger of killing someone. Repeatedly she implored me to tell her why she worried so much about being locked up, but she had little to say about her real problem.

Another woman made this statement: "When my mother asked me whether she might commit suicide, I gave her permission because at that moment I felt only her feelings. I was completely identified with her. My own feelings and wishes were unimportant." The thought of being touched by someone overstimulated this patient, who dreaded any kind of physical contact.

Attempts at Compensation

Harry, a teen-ager whose treatment I supervised, gave abundant evidence of his lack of insulation. His case history (Chapters 15, 16) illustrates how the schizophrenic personality attempts to compensate for this weakness. When he entered psychotherapy, Harry communicated many feelings of being overstimulated by his mother's closeness and seductive behavior. He frequently spent the whole day in bed, rolled up in blankets like a mummy and with his head practically glued to his radio. When he did go outside, he kept close to buildings and avoided speaking to acquaintances.

When asked why he clung obsessively to the same topic session after session, he said that he always hammered away at one subject at a time. "It's like shutting myself up in a back room and shutting out everything else," Harry explained. "I hammer away and it is like grabbing for some security and also justifying myself that I am right." In this situation, the youth employed simultaneously five characteristic patterns of insulation: self-isolation, shutting out stimuli, forceful repetition as a protective pattern against new stimulation, clinging to one idea, and self-justification.

A person entering treatment for some condition other than schizophrenia may also be inadequately insulated, but whereas he generally appears to have some confidence in his eventual ability to control his own behavior, the schizophrenic betrays a complete lack of confidence in this respect. His attempts to deal with the pressure of his needs are, in consequence, much more primitive, and they engross his whole personality. The ego, which remains relatively free in other conditions, becomes involved to an all-encompassing degree in schizophrenia. All of its energy is invested in compensating for the inadequate insulation. To remove himself from the danger of being overstimulated, the schizophrenic resorts to pathological narcissism and emotional seclusion. He sacrifices his ego to insulate himself against the danger of destroying his object (Chapter 10).

THE NORMAL PROTECTIVE COATING

It is important to understand why the schizophrenic's life experiences tend to overexcite him and prepare the ground for impulsive behavior. A review of the processes by which the mind normally acquires its protective coating may help to clarify the precise type of emotional training that the schizophrenic patient needs to experience.

Insulation of the human organism begins before birth. The mother's body, prototype of the protective barrier, provides a shock-free atmosphere where the insulative process begins as an aspect of the physiological growth of the embryo. It is protected in various ways from the excessive impact of the surrounding organs—the impinging environment. For example, shortly after conception, the organism is securely implanted in the uterine cavity and encircled by protective membranes. The placenta mediates its needs with the maternal economy. The amniotic fluid cushions the soft tissues, maintains a comfortably warm temperature for the embryo and, in due time, eases its birth. Need I say more about the insulating properties of intrauterine life? The analyst is familiar with this lost paradise and the traumatic experience of being expelled from it.

With the birth of her infant, the mother continues to perform her insulative role; but she shifts from the involuntary biological operations of the gestation period to voluntary activity that will facilitate his adjustment and growth in a more rigorous environment. To take over voluntarily and consciously the role that she performed involuntarily and unconsciously for nine months is a task that she generally finds very difficult. She must now minister to the baby's physical needs and their psychological concomitants. Chief among these needs are nourishment, sleep, bodily contact, mild tactile stimulation, protection from noise, glare, and other intense sensory influxes that would give rise to instinctual tensions. By meeting the infant's maturational needs through the proper balance of gratification and frustration, she helps to prepare his body and mind to take over the task of insulating himself.

The growth process itself also lays down protective coatings. Nervous tissue is sheathed in myelin, its insulating substance, during the first few years of life. Motor coordination is very important; when the child is able to walk, he can remove himself physically from dangerous situations. Talking is another skill that can be employed to reduce tension. The child who can tell his mother explicitly that he is cold or wet or has a bellyache is spared the distress of the woman I treated who recalled having a bottle stuffed into her mouth every time she cried. About the age of four, the youngster begins to acquire the outer layer of its protective coating—powers of comparatively rational thought and actions. At that point the mother's role becomes less significant.

An important aspect of this cooperative enterprise is the exchange of positive feelings. In the infant who experiences love from his mother, feelings of love toward her and toward himself are stimulated. Eventual awareness of these shared feelings is a great new source of gratification for him. The capacity to love the self and the object develops through the introceptive feelings that a loving mother generates in her infant by sensing his needs and responding to them with intuitive understanding. Her reinforcement of his love responses has an insulative value. On the other hand, strongly negative feelings stimulated in him tend to reduce the strengthening effect of positive feelings and lead to distorted perceptions of the parent. It is my impression that schizophrenic patients, as infants, were oversensitive to negative introceptive feelings—their own and those of the mother and other adults.

FAILURE TO ACHIEVE PROTECTIVE COATING

External Stimuli

If the maturational team does not succeed in building up a good protective barrier in the child, who is to be held accountable? I do not subscribe to the tendency to attribute this failure to either the "schizophrenogenicity" of the mother or some irreversible genetic or constitutional deviance in the child. Let us just say that they did not click as a team. For one reason or another, equilibrium between the mother's handling and the child's impulsivity was impossible to achieve. There may have been tension in the relationship from the beginning. The mother may have found the child exceedingly difficult to bring up, hypersensitive and hard to understand or please even if his needs were within normal limits. If she did not sanction overt expressions of hostility, she may have responded to the child perfunctorily when he provoked murderous impulses in her, and trained him to regard the discharge of hate tensions, either in rage or action, as highly undesirable.

Patients often report that they were not allowed to hate their parents. Not only were they not supposed to say that they did; even to think or feel it was prohibited. Some patients, terrified that the presence of their negative thoughts and feelings would be recognized by their parents, did everything possible to prevent themselves from becoming aware of them.

To a certain extent these are speculations, but the behavior of the schizophrenic patient points back to early bouts with overstimulation and pro-

schizophrenic patient may be anti-social in his behavior, but actually he is a very social-minded human being. Too social-minded, in fact, for his own good. He unconsciously sacrifices his ego to preserve his object. What he has to learn is that both can survive.

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longed frustration during which he developed a pattern of going out of contact to buttress himself against the mobilization and discharge of his destructive impulsivity. To stifle impulses to attack his object physically, he ran away from it psychologically into non-feeling states and self-preoccupation—an involuntary and impulsive narcissistic defense. The pressure of this impulsivity fragmented his ego and disrupted its insulation function. Hence, the regulatory mechanisms that normally maintain the reservoir of psychological energy at a pleasurably low level either failed to develop or became inoperative.

Internal Stimuli

It is important to keep in mind the two aspects of the schizophrenic problem: too much stimulation and too little discharge. The absence of adequate discharge patterns has been obscured to a considerable extent by the tendency to focus on the inadequacy of the mind's protective barrier against external and internal stimuli. But the building up of intermediate barriers between stimuli and discharge that serve to delay or store up the response to stimuli is at least as important as the initial screening out of stimuli. It is my impression that the early failure to develop adequate discharge patterns plays a larger role in producing the illness than the weakness of the barrier against stimulation.

This impression may not be supported by the clinical picture, but neither does the clinical picture of the person suffering from autointoxication indicate that the key to his recovery is the elimination of the poisonous substances that have accumulated in his body. The would appear to be a fair analogy. The resemblance between the manifest symptoms in the two conditions has often been noted; indeed, the theory that schizophrenia is a psychological form of autointoxication was frequently discussed several decades ago.

The somnolence, nausea, cramps and other symptoms of the victim of autointoxication may create acute tension, but the direct alleviation of these symptoms does not cure the condition. The physician focuses his attention on draining the toxic substances from the body and, if the condition is chronic, on setting up a regimen for the patient that will prevent the toxins from being produced in the future. Similarly, in schizophrenia, the alleviation of the anxiety caused by the pressure of high accumulations of destructive impulsivity dammed up in the mental apparatus will not resolve the illness. The patient's fundamental need is to develop the ability to engage in the verbal release of feelings, especially aggressive feelings. It goes without saying that this encompasses a great deal more than simple cathartic release, which gives only temporary relief. Treatment has to be structured to

provide the patient with the situations required for the creation of action patterns that will facilitate the discharge of aggressive energy in socially desirable ways whenever it builds up in the future (Chapter 3).

FREUD'S EARLY FORMULATION

In the emotional training of a child, the building up of the protective barrier against stimulation is probably more important than the organization of action patterns. Under normally favorable conditions, the mind acquires sufficient patterns as an aspect of maturational processes. This may help to explain why Freud tended to focus on the problem of oversensitivity, as in the passage quoted above.

However, exactly twenty-five years before this work was published, he addressed himself to the problem of discharge and, in a sense, actually suggested the rationale of the clinical approach we are exploring. In an unfinished manuscript written and sent to Wilhelm Fliess in 1895, Freud identified discharge as the mind's primary function. This manuscript, though a product of that early period when his collaboration with Breuer had scarcely ended, did not come to public attention until 1950, when it was published in the original German with the letters to Fliess.

The editors of the English version, issued a few years later, entitled the document, "Project for a Scientific Psychology" (1950). Freud himself refers to it, in the text, as a study on the "structure of quantitative psychology" (p. 311). The study was undertaken, he writes, with the intention of furnishing "a psychology that shall be a natural science" (p. 295). In other words, he was attempting to integrate the findings and terminology of other sciences into psychology, and to discuss the mind without resorting to the aura of mysticism that usually surrounds such a discussion. Some of the formulations in this paper were further developed and appear piecemeal in Freud's later works, but he abandoned the general scheme, apparently in the belief that it was taking him up a blind alley. Nevertheless, the 1895 draft is well worth reviewing now, in view of its amazing relevance to some of the most recent findings in neurophysiology.

Freud's project in quantitative psychology was based on clinical observations, especially those concerned with "excessively intense ideas" (p. 295). Approaching such excitation as "quantities," he suggests that the nerve cells or neurons operate in accordance with "the principle of *inertia*" (p. 296); that is, they tend to divest themselves of these quantities, discharging the excitement into various connecting paths in order to get rid of it. Freud continues: "This discharge represents the primary function of the nervous systems" (p. 296).

Clearly, Freud in 1895 regarded discharge as more important than stimulation. The correctness of this view becomes pretty obvious when one stops to think about it. The reception of stimuli is not crucial for the survival of the organism, but action is crucial. Birth is contingent on both mother and infant engaging in activity. To survive, the neonate must breathe. From the point of view of the nervous system, breathing is a discharge process. Although different sets of muscles are involved in inhaling and exhaling, activity of these muscles always initiates discharge by the nervous system. The discharge of nervous energy is the first requirement of human life.

What Freud calls "contact-barriers" (p. 298) hold up the discharge of nervous excitement between the cells. He theorizes that there are at least three groups of these cells, one group governing the intake of stimuli, another governing memory, and the third consciousness. The stimulus system tries to keep the energy received down to zero. The endings of the nerve cells in this peripheral system perform the function of screening or damping down the amount of energy flowing through the system, thus holding back the energy or discharging it. The reservoir of psychological energy is usually maintained at a low level through these screening and discharge processes, which figure in the concept of insulation.

The group of cells dealing with memory has the additional insulative effect of being out of direct contact with the external world. However, overexcitation and eruptions of large quantities of external stimuli indirectly reactivating the memory system cause pain, according to Freud. Pain signifies a failure or breach of continuity in the contrivances he describes.

The thesis that the schizophrenic's pathological defensive maneuvers represent an unconscious attempt to flee from painful stimulation would appear to coincide with this early formulation by Freud. He makes other points relevant to our discussion; unfortunately, we cannot linger any further on this interesting study in quantitative psychology. However, I want to make brief mention of another idea that he stated in 1895 because it is so reminiscent of the latest findings on the physiology of the brain. Stimuli are registered in the nervous system in what are called "periods" in this study. It suggests that the sense organs operate not only as screens against quantity of stimuli but also as sieves, which admit stimuli from "only certain processes with a particular period" (p. 310). This comes remarkably close to current notions of energy waves and "scanning" in the brain.

PENFIELD'S STUDIES

Further support for Freud's theories detailed above has come from published reports of neurophysiologists, especially Wilder Penfield and his

associates who have continued his investigations at the Montreal Neurological Institute. I have already referred to their findings derived from electrical stimulation of the temporal lobe of epileptic patients undergoing brain surgery. In 1936 Penfield initiated a study of the so-called stream of consciousness that the brain seems to preserve; he likens it to a continuous film strip with a sound track. He summarizes his findings in *Speech and Brain Mechanisms*.

As I cite a few passages from the book (Penfield and Roberts, 1959), it would be helpful to bear in mind that the processes he describes are similar to those observed in patients in the course of analytic psychotherapy. Especially pertinent is the following passage:

> The business of the brain is carried out by the passage of nervous impulses from ganglion cell to ganglion cell in an orderly and controlled manner. The impulses pass quickly along the *insulated nerve fibers* like an electrical current. . . . If some area is injured by disease or pressure or lack of oxygen, the gray matter, although it may continue to function, may do so with abnormal additions of its own. There seems to be a *defect in the regulating mechanisms which normally limit excessive discharge* (p. 6). [italics added]

As this statement suggests, healthful activity of the brain requires moderate discharge. Maximum discharge is dangerous; this is what produces the epileptic fit and leads to psychosis, homicide, and suicide. When the integration of brain functions does not insulate the mind adequately, it resorts to regulatory inhibitory mechanisms to provide more insulation. Indeed, the defenses which operate in patients during psychotherapy, notably the narcissistic defense in schizophrenia, might be regarded as sluice gates that limit discharge, to prevent it from reaching the danger point.

A central integrating system within the higher brain stem appears to coordinate the numerous forms of activity that go on in the nervous system. Its psychical responses to stimulation are of two kinds, designated as *experiential* and *interpretive*. Electrical stimulation of certain portions of the temporal lobe cortex produces these responses, according to Penfield.

The stimulation of one area produces a flashback to some past experience of emotional significance. As the patient lives over some previous period in his life, he becomes aware of something more than his memory of that time. "He has a double consciousness. He enters the stream of the past and it is the same as it was in the past, but when he looks at the banks of the stream he is aware of the present as well" (p. 45). This should sound familiar. One of the goals of analytic treatment is the verbal discharge of the stream of the past.

Application of the electrode to another area of the temporal lobe produces the interpretive responses, those concerned with the process of

comparing past and present that figures in the making of useful judgments. In some cases, however, electrical stimulation of the area led to false interpretations of the present—*deja vu* phenomena and other perceptual illusions. Emotions not justified by the relation between the new stimuli and past events were produced. For instance, fear was aroused by the anticipation of some threatening perception even though there was no realistic basis for the fear. In brief, neurophysiologists confirm the findings of psychoanalysts that people may suffer from memories and that overcharged memories can lead to inappropriate emotions and improper actions.

In the most primitive type of functioning, stimuli are received and discharged immediately into action. Discharge into feelings and language has been demonstrated to be a much more complex operation, involving many more brain cells, brain systems and integrating mechanisms. It has been estimated that more than two hundred muscles and their controlling brain centers engage in coordinated activity when a person speaks.

IMPLICATIONS FOR PSYCHOTHERAPY

The findings just reviewed shed some light on what transpires in a patient's nervous system during the psychotherapeutic process. They also suggest that, when we ask him to cooperate in the two-fold task of developing healthful forms of insulation and the appropriate verbal discharge patterns he needs, we are actually making enormous demands on the patient. These demands involve the reorganization and reintegration of his nervous system.

Any kind of talking won't do this job. The exceedingly intricate neurophysiological mechanisms involved in talking are utilized to secure the release into language of certain feelings that were associated with highly charged emotional experiences. The patient must verbalize the destructive impulses that he has been holding in check through pathological forms of insulation. If he does not possess sufficient patterns for verbal discharge, he has to be assisted in developing additional patterns. Meanwhile, healthful forms of insulation must be built up to enable him, eventually, to give up his narcissistic defense. But until these more desirable methods of inhibiting destructive action are fully established, the narcissistic defense has to be maintained (Chapter 10; Spotnitz and Nagelberg, 1960).

With this understanding, I conduct the treatment of a schizophrenic patient entering analytic psychotherapy in accordance with three general principles: (1) to provide him with a non-stimulating treatment climate; (2) to train him not to discharge his feelings into action in my presence; and (3) to work from the beginning of treatment to build up the insulative capacity of his ego, reinforcing it as necessary in the process.

Initial Climate

The problem of oversensitivity is focused on from the opening session. External and internal stimuli expose the schizophrenic ego to undue pressure. The reservoir of psychological energy has to be maintained at a low level while the insulative capacity of the ego is being built up. Hence, the need for a non-stimulating climate is obvious.

It might appear that such a climate would be created if the analyst kept quiet. However, silence may at times be more stimulating than words. A great deal of anxiety can be produced by too much silence as well as by too many words. The anxiety level of the patient has to be studied, to determine whether silence or a communication would be more therapeutic in a particular situation.

Although generally a good clue, the anxiety level does not invariably indicate how to protect the patient from overstimulation; anything one does raises the anxiety level in some people. In these cases it may be helpful to space communications instead of operating in relation to the anxiety level. For example, one woman I am treating became extremely anxious when I was quiet. On the other hand, communications to reduce her anxiety had the opposite effect; her recognition that anxiety was rewarded with communication served to increase her anxiety. The best way out of this dilemma, I found, was to alternate brief periods of communication with brief periods of silence. Thus far, this schedule has proved therapeutic for this woman; but if she becomes aware of what I am doing it may be necessary to change the schedule or devise some other means of protecting her from overstimulation.

Discouraging Destructive Action

The process of educating a patient to the idea that his feelings should just be articulated, not acted on, gets under way with the start of treatment. In accordance with the general principle of keeping my own interventions at a minimum, if a patient appears able to proceed and behave appropriately without explicit instructions, I prefer that he continue that way. Otherwise, he is instructed to tell the story of his life in any way he wishes. He is also permitted to remain silent when he prefers that to talking. But it is important to inculcate the idea that talking and keeping quiet are the only activities encompassed in the treatment relationship.

I formalized this principle after several narrow escapes from murder convinced me that I did not want patients to engage in motor activity when in the room with me. I decided that, if I wanted to live and continue to function in the field, I had better lose no time in conveying, preferably by impli-

cation, the message: Just talk; don't act. Of course, this serves to heighten the transference because, as I pointed out earlier, survival depends upon discharge—action. When a patient with a terrific drive to act is told, "Don't act," aggressive forces are mobilized in his personality. He feels that you are trying to destroy him. However strongly he feels this, the freedom granted him to verbalize the feeling signifies that you will permit him to live.

Increasing Insulative Capacity

Once the hostility has been drained off, communications that are specifically designed to stimulate are involved in the process of increasing the insulative capacity of the patient's ego. Other communications are planned to provide substitute forms of insulation; these are required to reinforce the healthful non-conducting materials the ego possesses, and to help it outgrow the need for pathological forms of insulation. In a sense, the therapist serves as the protective barrier as long as may be necessary to tame the patient's impulses to act, to block up destructive action patterns which short-circuit emotionally significant verbal communications, and to prevent the puncturing of weakly insulated areas of the ego.

The degree to which an individual will be stimulated by the presence and behavior of another is difficult to control, let alone anticipate. My most reliable guide is the patient's contact functioning: his conscious or unconscious attempts to elicit some response from me as he resists talking about himself in a mature way. I study these attempts and psychologically reflect them in my own communications.

Contact functioning generally operates as a resistance in the analytic situation, but its investigation and reinforcement have two special values in working with a schizophrenic patient. His attempts to make contact clarify the nature of his relationship with his original objects, thus providing clues to his precise needs for insulation. In other words, his contact functioning tells one how to go about insulating his ego. Moreover, the reflection of the attempts at contact--that is, acting as a twin image—gives the patient the feeling that he is doubly protected against improper behavior.

Reinforced in this way, the ego feels more secure. Feelings of security have a high insulation value. So do healthy identifications. Positive introceptive feelings are strengthened; negative ones are detoxified through this psychological method of child rearing. This approach is designed to create the special kind of object relationship that a severely regressed patient needs to work effectively on his preoedipal problems and put his ego in good control of his energy systems.

By responding in the manner indicated by the patient's contact functioning, the therapist presents stimuli that are carefully controlled by the patient and will thus tend to reduce his narcissistic activity.

Frustration Dosage

Resistances are handled in an entirely different way than that dictated by the standard procedure (Spotnitz and Nagelberg, 1960). The patient is not put under any pressure to overcome them; as a matter of fact, he is helped to preserve his resistances and even to strengthen them at times because of their insulative value. The aim is to prevent him from accumulating more destructive impulsivity than he is able to release verbally. Hence, the frustration dosage to which he is exposed is mild. He is not overindulged with gratification either. He is given just enough to make him want to struggle for more, and to convince him that the struggle is worthwhile.

Some analysts concentrate first on the positive transference. The negative aggressive patterns receive relatively little attention. But I have not found this approach effective with a patient who has stored up intense rage reactions, at great cost to his ego (Chapter 10). His primary need is to discharge his hate tensions in socially acceptable ways. Libidinal impulses may also be troublesome for a schizophrenic but, in my experience, his hostile ones are far more dangerous to himself and others.

Some schizophrenic patients talk hour after hour about their incestuous feelings for a parent without getting any better; but they clam up at the thought of damaging the object. Had Oedipus been a well-defended schizophrenic instead of the prototype of a psychoneurotic, he might still have committed incest with his mother, but he would have run away from his father. The schizophrenic does not kill his object unless his ego is completely overwhelmed by psychosis and compelled to engage in destructive behavior.

The first lesson the schizophrenic patient has to learn—and the hardest to teach him—is that frustration-aggression *can* be discharged appropriately in words, that language *is* powerful enough to liberate him from the most hateful situations.

Goal-Oriented Interventions

When to talk and when not to talk is an elementary concern to the analytic psychotherapist. "Talk when you have something to say," though a good rule of thumb for the treatment of neurotic patients, does not meet the special needs of one who is schizophrenic. I may talk to such a patient when I have the impression that a particular communication will facilitate his development of additional discharge patterns. I have already referred to the use of communication to reduce the anxiety level of the patient. Other types of communications may be helpful in producing verbal discharge or in keeping his hostility from reaching unbearable heights. The important consideration is that all of the therapist's communications be goal-oriented.

Goading, reassurance, or emotional support are inadvisable. Early in treatment, I give interpretations only when they will help the patient improve his immediate functioning. Interpretations are contraindicated when they tend to make him more absorbed in himself or are felt as narcissistic injury. Experience has demonstrated that exposure of a schizophrenic patient to objective evaluations of himself before his protective barrier has been built up may easily compound his difficulty because, right or wrong, they tend to puncture his ego.

The theoretical formulations presented here are addressed to the twin problems of overstimulation and inadequate verbal discharge patterns, primary concerns in the early stages of the psychotherapeutic process. In order to resolve these problems, the therapist operates in such a way that the patient feels that he and the therapist are one. This facilitates the development of a strong transference on a narcissistic basis. The security derived from this relationship eventually makes it "safe" for the patient to become aware of the therapist as a different object. At that point, the narcissistic transference is superseded by an object transference. After this develops, the treatment of the schizophrenic is not basically different from that of a neurotic undergoing psychoanalytic psychotherapy, and presents no special problems to the goal-oriented therapist.

CLINICAL ILLUSTRATION

To illustrate how the concept of insulation is implemented in treatment, I shall return to the case of the schizophrenic youth I refer to as Fred.*

During his first two sessions, Fred talked freely about childhood events and his quarrels with his parents following the breakdown which had cut short his college career. He complained that he felt dead; agitated and restless, he asked if he was talking the way he was supposed to talk. Repeatedly he called my attention to his distress. Frightened by it, he made several rather feeble attempts to solicit some response. For example: What was I interested in? Did I have any hobbies? Questions such as these were followed by provocative remarks, such as, "This couch must be older than I am."

I psychologically reflected these communications; that is, I directed a similar question or remark to Fred but gave no factual information. His resentment mounted with each response. A therapist who objects to working with an angry patient will undoubtedly regard this strategy as improper,

*Material from the same case was presented in earlier papers to illustrate other aspects of treatment (Spotnitz and Nagelberg, 1960; Chapters 5, 10).

because my reflection of Fred's contact functioning made him very angry with me. However, the more I talked as he did, the more secure he felt, and his mounting feelings of security enabled him to verbalize a great deal of anger. Toward the end of the second session, he threatened to tear the office apart. Asked what damage he would do, he replied that he would break the windows and smash the desk lamp. But that would just be the beginning. He was reminded that he was supposed to verbalize his feelings, not act on them.

This instruction was repeated during the third session. Fred answered that he had no intention of cooperating. He hadn't wanted to come in the first place. What right did his father have to force him into treatment?

"Then why don't you stop?" I asked him. "If you don't want to be treated, you don't have to be."

"You're only saying this because you know my father won't let me stop," he replied. "You know I can't buck him."

"No, I'm serious about this," I told Fred. "If I tell your father that you should stop, he will believe me."

I meant what I said, but Fred did not believe it until we had talked and talked about his leaving treatment for the next two sessions. By that time, he was convinced of my sincerity. Needless to say, had I not meant what I said, this strategy would have led to failure. He shook my hand for the first time, and thanked me profusely. As he was about to close the office door, I called out after him, "Remember now. Don't come back unless you yourself really want to be treated."

The series of interventions just reported represented a therapeutic maneuver to increase the insulative capacity of Fred's ego so that he could defy his father and refuse to be forced into treatment. The maneuver also made it possible for him to express his objections to having anything to do with me at that time.

Fred's father telephoned two days later, and was informed that the young man had not misrepresented the situation. He himself was not heard from for ten days. Then he telephoned and pleaded for an appointment "right away." He added, "I really want to come no." His return to treatment was arranged for the same day.

Fred's ego was now able to accept the idea of treatment. Successful defiance of his father made it possible for him to commit himself to it voluntarily.

When he came to the office later in the day, Fred explained that he had come to the previous sessions just to "see how things would go." He had felt too cracked up to talk. But he had been so miserable at home during the last few days that treatment couldn't possibly make him feel worse. Although

he experienced great difficulty in involving himself in the therapeutic process, only one more break in treatment occurred.*

Fred's resistance patterns were psychologically reflected at times to communicate my awareness of his misery. To cite one example: He talked about wanting to take a trip to California, proceeding from there to Alaska. "That sounds like a wonderful idea," I told him, "but why limit yourself to this continent? There's so much more to see in the rest of the world. Why not make the trip really worthwhile by taking a boat to Australia, especially New Zealand?" I joined Fred in his wanderlust to insulate him more adequately against his strong impulses to throw up the sponge and spend the rest of his life as a footloose hobo. At that time, he really relished the idea of becoming a hobo.

He made many attempts to control his anger by asking me to relieve him of his emptiness and misery. I did not offer reassurance, but asked why I should relieve him. This insulative maneuver produced an outburst of rage. He thundered, "I hate you for permitting me to go on tormenting myself."

Fred tended to attribute his continuing improvement wholly to my communications, ignoring the importance of his own verbalizations. Hence, he sought to control situations to obtain whatever emotional nourishment he craved. When this verbal feeding was not forthcoming on demand, he was apt to explode again. In one moment of fury, he reached for a bronze ashtray and shouted, "Stop this stalling and talk to me." Of course, the immediate response was a reminder that all force was to be turned into language. "No action, just talking, please."

When he threatened bodily assault during another outburst of rage, it was pointed out that he did not hold the whiphand. Plenty of damage could be done to him before he had time to get off the couch. Reflection of Fred's own threats helped to insulate him against carrying them out. My repetition of the threats served to assuage his guilt about them. He felt no need to defend himself since he was convinced that I would not harm him; but the fact that I could comfortably say I would made him feel more secure about verbalizing his own destructive impulses.

In other situations questions were put to Fred to help him talk about any subject that came to his mind. His attention was directed away from himself toward the consideration of objects.† He was educated to the idea that it is

*This took place about four years later, when Fred missed a session because he suddenly felt a "call" to visit a childhood sweetheart he hadn't seen for ten years. His irresistible urge to find out whether their love had survived the long separation led Fred into a disappointing experience. His trip of several hundred miles ended, surprisingly, in a maternity hospital, where he was greeted by a young woman holding a newborn baby in her arms. Obviously, she was very much in love with her husband.

†This maneuver, which has an insulative effect, is sometimes employed in the initial interview with a person who becomes very disturbed in talking about himself, especially when he focuses on his functional difficulties. Steered into an object-oriented discussion, he usually becomes more relaxed.

normal to express feelings of hostility when one's emotional needs are being frustrated. Other interventions helped him discharge instinctual tensions while he was being insulated against action. The verbal release of the tensions also tamed his impulses to behave inappropriately.

Fred was conditioned to the verbal discharge of his object interests. Such conditioning figures significantly in the insulating process. When he felt secure enough to attach himself to new objects, Fred found that he could satisfy his emotional hunger without being overstimulated. He developed a terrific drive for work, went to night school, and made friends with several of his fellow students. He also started to date girls.

His narcissistic preoccupations waned as he discovered that his work, studies, and social activities brought him much more satisfaction. He began to operate like a confident human being with a well-insulated ego.

FUNCTIONING WITH ADEQUATE INSULATION

The clinical material presented above supports the hypothesis that schizophrenia represents a pathological mode of insulation against the destructive effects of undischarged aggressive energy. When the goal-directed therapist operates in terms of this understanding to build up the insulative capacity of the ego, and help it develop appropriate patterns for the discharge of this energy,* the patient is able to function without recourse to ego-sacrificing forms of insulation.

The scarring of the ego caused by the schizophrenic process cannot be completely obliterated, but evidence of past pathological tendencies will only be found through careful diagnostic testing or interviewing in later life. The acquisition of a mature ego—that is, a well-insulated ego commanding an abundance of patterns for verbalizing emotions—tends to immunize a person against the return of the illness.

Experience with schizophrenic patients convinces me that one cannot help them meet their maturational needs solely, or even to a major extent, through the use of words alone. It should be emphasized that the use of special techniques is subordinate to the genuine desire of the therapist to understand such a patient and help him preserve his ego. The therapist with the right feelings can develop maneuvers which, properly timed and applied, will build up the insulative capacity of the patient's ego and enrich its patterns of self-expression.

*Perhaps this is analogous to setting an example for the patient, an illustration of paradigmatic strategy (Coleman and Nelson, 1957).

Resolving obstacles to the meeting of the patient's maturational needs is the objective of those therapists who, though guided by psychoanalytic understanding, use whatever ingenuity is required to develop the appropriate emotional and thought responses, rather than limiting themselves to any single procedure. Ultimately, I believe that the special approaches being developed for the treatment of the preverbal personality will facilitate the emergence of a more efficient form of psychotherapy for both verbal and preverbal personalities—a modern form of psychoanalysis.

12

Techniques for Resolving the Narcissistic Defense

The clinical phenomena analyzed in the present chapter inspired Freud's reference to the "wall which brings ut to a stop. . . . 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 and spy out what is going on on the other side of it" (1917, p. 423). Subsequent explorations substantially modified the bleakness of Freud's impression and emphasized the conclusion he drew from it: His own therapeutic method would have to be replaced to deal effectively with the narcissistic defense. Such a method can, nevertheless, be formulated and conducted within the basic framework of Freudian psychoanalysis.

The method described here has been employed for many years by analytically trained psychotherapists in the treatment of adults, adolescents, and children, with appropriate modifications, in private practice and psychiatric clinics. An application of the method in a short-term therapy program for six hospitalized patients is reported by Davis (1965-1966). Although the majority of patients have been schizophrenic or borderline cases, this approach has been applied also in other conditions marked by regression to preverbal levels of functioning, notably severe depression, hypochondriasis, and psychosomatic disorders. A gross inability of the patient to manage the release of aggressive impulses in healthful and socially appropriate ways has been viewed as an indication for the use of the method.

Effective application of the method is contingent on recognition of hostile impulses in the patient and the effects they induce in the practitioner (Win-