On the Treatment of Psychotic States by Psychoanalysis: An Historical Approach

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During the last 50 years the psychoanalytic approach to psychosis has undergone very considerable change and at the present time there is no unified theory of either the psychopathology or the technique of treating the psychoses. Many analysts working with psychotics have found it necessary to alter to some extent the classical technique of analysis developed by Freud in dealing with neurotic states; a technique which relies predominantly on the development of transference manifestations which can be interpreted to the patients. Freud himself thought, as I shall show later, that this technique was unsuitable for psychotics. The work of many analysts has been influenced by Freud's belief that psychotics do not develop a transference. However, an increasing number of analysts have tried to develop methods with the hope that eventually some contact with the psychotic, and with this some improvement of the psychotic condition, might be achieved.

In discussing the motives of analysts, such as Rank, who have branched off from psychoanalysis, Freud ***(1933)*** felt that responsibility must be laid on the intimate relations which exist in psychoanalysis between theoretical views and therapeutic treatment.

The changes in the therapeutic approach to psychotics are certainly influenced by the theoretical views held by the therapist and by factors in the therapist's own personality.

A clearly defined method of approaching psychotic states is important if we expect to do research to clarify the psychotic psychopathology rather than concentrating on symptomatic improvement. The therapist should ask himself whether he is inclined to change his psychoanalytic approach because he does not understand the psychotic patient or because he believes he has arrived at a better understanding of psychotic psychopathology, and that alterations in technique are the outcome of his understanding.

In fact, many analysts have found that deeper understanding of psychotic psychopathology made it unnecessary to change the usual classical psychoanalytic technique to any important degree. I shall try to indicate some aspects of the theoretical background of the therapies I am describing so that the theoretical reasons for any change in psychoanalytic technique can be seen.

Modifications in analytic technique are particularly common in the approach to schizophrenics but not in work with manic-depressive patients. That is probably one of the main reasons why the number of descriptions of psychoanalytic therapy with manic-depressive patients is comparatively small compared with the extensive literature relating to the treatment of schizophrenia. In this paper, therefore, I shall concentrate mainly on the latter group.

I shall first attempt to give a picture of Freud's views relating to the treatment of psychosis. Freud made many basic contributions to the understanding of the psychopathology of the psychoses and undertook the treatment of some psychotic patients, occasionally with success. For example, as early as 1904, he reports an attempt to treat a manic-depressive patient in the symptom-free interval after the depression. However, the treatment came to an end after a few weeks when she became manic. In 1916 he reports that he had two successes in treating similar states. In 1905 he states:

Psychoses, states of confusion and deeply rooted depression are not suitable for psychoanalysis; at least not for the method as it has been practised up to the present. I do not regard it as by any means impossible that by suitable changes in the method we may succeed in overcoming this contra-indication—and so be able to initiate the psychotherapy of the psychoses.

Freud felt that analysts should limit their choice of patients to those who possess 'a normal mental condition', since in the psychoanalytic method this is used as a foothold from which to obtain control of the morbid manifestations. This links up with his later formulations that some normal ego functioning was necessary in order to begin any psychoanalytic treatment. In 1916 he explained his views in much greater detail, linking them with his developing ideas on the importance of narcissism. After discussing the withdrawal of the libido from the object into the ego as an important factor in the psychopathology of dementia praecox and also the manic-depressive states he says:

Since we have ventured to operate with the concept of ego libido the narcissistic neuroses have become accessible to us: the task before us is to arrive at the dynamic elucidation of these disorders and at the same time to complete our knowledge of mental life by coming to understand the ego.

He continues:

The ego-psychology after which we are seeking must not be based on the data of our self-perceptions but on the analysis of disturbances and disruptions of the ego. ... But hitherto we have not made much progress with it. The narcissistic neuroses can scarcely be attacked with a technique that has served us with the transference neuroses. You will soon learn why. What always happens

with them is that, after proceeding for a short distance, we come up against a wall which brings us to a stop. Even with the transference neuroses, as you know, we met with barriers of resistance, but we were able to demolish them bit by bit. In the narcissistic neuroses the resistance is unconquerable.

He continued a little later:

Our technical methods must accordingly be replaced by others; and we do not know yet whether we shall succeed in finding a substitute.

He then discussed the material available from psychotic patients with the clear intention of stimulating research into the psychopathology and treatment of narcissistic states, but the pessimistic note constantly returns, for example, in 1916 he discusses how

paranoics, melancholics, sufferers from dementia praecox remain on the whole unaffected and proof against psycho-analytic therapy,

and goes on to discuss in detail the so-called transference neurosis in order to explain the lack of success with the narcissistic neurosis:

Observation shows that sufferers from narcissistic neuroses have no capacity for transference or only insufficient residues of it. They reject the doctor, not with hostility but with indifference. For that reason they cannot be influenced by him either; what he says leaves them cold, makes no impression on them; consequently the mechanism of cure which we carry through with other people cannot be operated with them.

He then explained this lack of transference in terms of the patients having abandoned their object cathexes and the object libido having been transformed into ego libido. Sixteen years later, Freud ***(1933)*** again discussed the indications for and limitations of analytic treatment and issued a warning against over-enthusiasm about the results of psychoanalysis and now with his newer understanding of the importance of instinctual conflict he adds: sometimes one special instinctual component is too powerful in comparison with the opposing forces that we are able to mobilize. This is quite generally true with a psychosis.

He again discussed the limitations of analytic successes due to the form of the illness and says that the field of application of analytic therapy lies in the transference neurosis. 'Everything differing from these, narcissistic and psychotic conditions, is unsuitable to a greater or less extent.' It would seem that between the two series of Introductory Lectures Freud had become more pessimistic about the possibilities of *analytic* treatment of psychosis. This pessimism may, however, have been connected with his increasing preoccupation with the problem of the relation between the suitability for analysis and constitutional excessive strength of instinct, and his awareness of the importance of the destructive (death) instinct, in severe mental illness, which he developed in greater detail in 'Analysis Terminable and Interminable' ***(1937)***. In 1940, in 'An Outline of Psychoanalysis', Freud returned again to the discussion of the treatment of psychosis now related to his greater understanding of the psychology of the ego. He explained that the psychoanalyst has to find in the ego a useful ally so that the ego must have retained

a certain amount of coherence and some fragment of understanding for the demands of reality. But this is not to be expected of the ego of the psychotic: it cannot observe a pact of this kind. ... Thus we discover that we must renounce the idea of trying our plan of cure upon psychotics—renounce it perhaps for ever or perhaps only for the time being,

until we have found some other plan better adapted for them.

But later in the *Outline* he added a further point to this when he described that in many 'acute psychotic disturbances there remains in some corner of the patient's mind a normal person hidden'. He then discussed 'the view which postulates that in all psychosis there is a splitting of the ego'. He said:

You may probably take it as being generally true that what occurs in all these cases is a psychical split. Two psychical attitudes have been formed instead of a single one—one, the normal one, which takes account of reality, and another which under the influence of the instincts detaches the ego from reality. The two exist alongside of each other. The issue depends on the relative strength. If the second is, or becomes the stronger, the necessary precondition for a psychosis is present. If the relation is reversed, then there is an apparent cure of the delusional disorder.

But Freud himself did not go on to apply this finding to the treatment of psychotic states (see Klein, Bion and Rosenfeld).

When one reviews Freud's contributions to the treatment of psychotic states one is impressed by his pessimism but also his obvious hope that eventually some way of approaching psychotic illness may be found. The pessimism is

essentially associated with his belief that psychotics do not form a transference, based on his theory that in these narcissistic conditions when object libido is withdrawn into the ego, the object presentations are completely give up. Freud attributed the extreme rigidity in resisting any change which he encountered in the psychosis to the same process: 'narcissism'. He regarded the omnipotence of the psychotic process, for example, delusions and hallucinations, as attempts at restitution designed to regain objects of the external world. But this 'object libido' was similarly found resistant to any therapeutic analysis. A third important difficulty which Freud described was the ego deficiency in psychosis which he believed made cooperation in treatment impossible. Although he formulated the important idea about the splitting of the ego in psychosis into a normal and a psychotic part this was not related by him to therapy. Freud was aware that excessive strength of instincts played an important part in psychotic states but did not discuss specific psychotic conflicts between parts of the self, such as loving and destructive parts of self, based on his theory of the life and death instincts. He regarded the main conflict in psychosis as a conflict between the ego and reality.

Abraham made very important contributions to the treatment of psychosis, particularly to the manic-depressive states. As early as 1907 he discussed the psychopathology and treatment of dementia praecox, drawing attention to the similarities of the conflicts in hysteria and dementia praecox, for example, instancing

the imaginary pregnancies which are so common in dementia praecox, and which in their psychosexual genesis are entirely similar to hysterical pregnancies.

He also states that 'obsessive ideas constitute in many cases the most prominent characteristic of the illness'. In 1908 he examined the differences between hysteria and dementia praecox and came to the conclusion that

since we have traced back all transference of feeling to sexuality we must come to the conclusion that dementia praecox destroys a person's capacity for sexual transference, i.e. for object love.

He regards 'the negativism of dementia praecox as the most complete antithesis to transference'.

In attempting to psychoanalyse them we notice the absence of transference again. Hence psychoanalysis hardly comes into consideration as a therapeutic procedure in this kind of illness.

He describes the patient's interest or longing for some objects but says if they get it, it has no effect on them. In discussing the general lack of interest in objects and the lack of sublimations, he suggests that the psychosexual characteristics of dementia praceox are the return of the patient to auto-erotism and the symptoms of his illness are forms of auto-erotic sexual activity. Many of Abraham's observations, such as the preoccupation of the schizophrenic with auto-erotic masturbatory phantasies, have been confirmed by recent work.

In 1913 Abraham changed his view about the lack of transference in schizophrenia when he reported on the analysis of an undoubted case of dementia praecox, suffering from hallucinations: 'The patient during treatment soon proved himself capable of making a sufficient transference.'

In 1916 he reported on another case of dementia praecox. He said that 'a psychoanalysis

can be carried out with these patients just as well as with a psychoneurotic'.

In both cases the work was facilitated on account of the abolition of many inhibitions, 'the material lies quite near consciousness and in certain circumstances is expressed without resistance'.

In 1912 Abraham reported on the investigation and treatment of six undoubted cases of manic-depressive illness and it is interesting to see how soon he began to discover transference phenomena in this group of patients. One of these cases had suffered from severe melancholia for 20 years. At the time of the report he had treated the case for only two months but

during this time no further state of depression appeared but there were two states of manic accentuation which were far milder than previously.

In another case the effectiveness of analysis was shown in a striking manner. The treatment lasted for only 40 sessions. In the sixth case the treatment could be successfully completed in six months. He commented that the treatment had a 'remarkably good result'. Six months after ending the treatment there had been no relapse. Abraham stated that it is usually extraordinarily difficult to establish a transference in these patients who have turned away from all the world in their depression, but he stressed that in one case, simply by the help of psychoanalytic interpretations of certain facts and connexions, he succeeded 'in obtaining a greater psychic rapport with the patient than he had ever previously achieved'. In another case

he was astonished that after overcoming considerable resistance he succeeded in explaining certain ideas that completely dominat-

ed the patient and observed the effect of this interpretive work. The initial improvement and every subsequent one followed directly upon the removal of definite products of repression.

During the whole course of the analysis he could most distinctly observe thatt he patient's improvement went hand in hand with the progress of his analysis. He commented that in those patients who have prolonged free intervals between their manic and depressive attacks, psychoanalysis should be begun during the free period. Generally speaking, Abraham, though aware of the incompleteness of his results, in this paper felt very hopeful. He said: 'It may be reserved for psychoanalysis to lead psychiatry out of the path of therapeutic nihilism.' In 1924 Abraham made further very detailed observations of manic-depressive patients. Particularly interesting and important are his comments on the patient's behaviour in the analytic situation and his reaction to the analyst's interpretations. He said, for example,

We all know how inaccessible melancholic patients are to any criticism on the part of the analyst of their ways of thought: and of course their delusional ideas are especially resistant to any such interference.

A patient once replied, when he had tried to make an interpretation, that he had not even heard him. He described the narcissistic transference in one of his patients who used always to walk into his room with an air of lofty condescension, displaying superior scepticism about psychoanalysis. In another patient this attitude used to alternate with one of chronic humility. He felt that melancholics are capable of establishing a sufficient transference to justify analysts in attempting to treat them and that important changes could not be effected in a patient until he succeeded in establishing a transference on to his analyst. He stressed, as in 1912, the patient's capacity to respond to interpretations and observed that in some cases the patient's narcissistic and negative attitudes towards certain persons, or towards his whole environment and his high degree of irritability in regard to them, diminished in a way which never happened before.

It is interesting, therefore, that Abraham, unlike Freud, found it possible to establish a transference in manic-depressive patients and that, in spite of the strength of the patient's narcissitic behaviour during the analytic sessions, he was able to produce a change simply by means of interpretations.

There were only a very small number of analysts who attempted to treat psychoses up to 1935. Their main preoccupation was the problem of the patient's narcissism. Waelder ***(1925)*** attempted to find a theoretical and practical basis for the treatment of the narcissistic neurosis. He developed a hypothesis concerning the conditioning factors by which the psychosis comes about, or is avoided in those borderline characters in whom the phenomena of transition to the psychoses can be observed. He introduced the concept of the 'narcissistic repression', which seems, in his opinion, the basis of the withdrawal of the libido into the ego and which

is also the basis of psychosis. He introduced a further concept which he called the 'union of instincts', which involves the combination of narcissism and object libido, instancing people

who succeed in linking the narcissism with object libido in a manner compatible with reality which prevents the formation of patholgical psychotic symptoms.

He illustrated his theory with case material. Waelder argued that if it were possible to use the libido which is flowing back into the ego at the outset of a psychotic disease in such a way that the instinct would be combined with sublimation in a manner compatible with reality, and if this union was related to object libidinal processes which are accessible to the analytic methods we might hope to be able to find a way of curing the psychosis which has already broken out. The therapeutic task in these cases he described as 'sublimation of narcissism'. In discussing the transference, Waelder pointed out that the only form of transference which can be effectively established is the narcissistic one. Waelder tried to make clear that the characteristic feature of the therapeutic intent which the advises implies an intervention into a healthy part of the personality which has not got a narcissistic fixation. He therefore depended on the existence of such a part of the personality. Practically the treatment must begin with an extremely passive period which enables the analyst to find out what the possibilities are. The analysis is maintained with the narcissistic transference and generally speaking one has to advance hand in hand with narcissism, avoiding frustration in regard to the narcissistic ideal and steadily aiming at affording narcissistic gratification compatible with reality. Waelder stressed the self-knowledge of the narcissistic patient and his capacity consciously to influence his mind:

In psychosis of the schizophrenic type, insight into the mechanism has a markedly greater power of assisting recovery than in neurosis. All self-knowledge consists in the establishing of communication between different tendencies which hitherto were cut off

from one another. ... This is a rare case in which the patient's understanding of the genesis of his illness suffices to cure him.

Waelder is one of the first analysts to speak of a narcissistic transference. This transference is apparently not used as a basis for transference interpretations but as a vehicle for the directive influence which the analyst can bring to bear upon the patient. When Waelder discusses psychotic mechanisms and tendencies cut off from one another, we are to some extent reminded of modern concepts of split off parts of the self and the interpretation of mechanisms of splitting in psychotics and borderline psychotic states which plays an important part in modern techniques of treating the psychotic ego.

In 1933 Clark contributed to the treatment of the narcissistic neurosis and psychosis. He thought that it was the narcissism which constituted the first great barrier to any therapeutic approach and possible readjustment in the narcissistic neurosis. He said:

In using the technique of ordinary analysis in such cases we may learn a great deal about narcissism, but we fail to help the narcissist.

He developed in this paper his theory of the narcissistic fixation and how this might be approached and overcome by psychological treatment. He observed that the narcissistic ego has not developed beyond the infantile level of need for loving protection and support and the patient is regarded as having a special individual requirement for a longer period of dependence than non-narcissistic patients. His theory is that though the narcissist may need a longer time for development, there will eventually be a tendency to step away tentatively from his withdrawn position. He believed that the therapist should fall in with the narcissistic requirements of the patient, in other words his role should be that of the 'tender, all-giving mother'. In practice, that would mean that the therapist would lend himself fully to listening to and understanding the material being presented but approach it not in terms of analytic interpretation but with emotional sympathy which would ensure the patient complete harmony. The author noted that the relationship would later assume the conditions of ordinary transference analysis but through this 'fortified technique' the ego is given a chance to resume its interrupted growth at a speed of its own choosing. At one point the author asked whether

such a passive all-giving analyst might not merely heighten the idealisations of the patient without increasing his testing of reality and his discharge of energy into sublimating activities.

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To counteract this difficulty Clark suggested that the narcissistic identification which the analyst provides must be gradually tinctured with reality requirements. He stressed that, once the narcissistic transference is established, the procedure is very similar to that followed in the analysis of the transference neuroses.

The narcissistic shell must be broken through in order to expose the real weaknesses, the fears and dependent needs which lie behind.

The author gave some case material of a psychotic patient, but he did not report any significant clinical improvement by this treatment. Clark's theories and approach have many points in common with later workers interested in dealing with psychotics, such as Fromm-Reichmann's early attempts at treating schizophrenic patients and Winnicott's later theories and recommendations for approaching psychotic patients.

Waelder and Clark seem familiar with the concept of the narcissistic transference, but they are not concerned with describing the narcissistic attitude of behaviour of the patient in the analytic situation, which had been done successfully by Abraham. They both advise the analyst to change his behaviour and to fit in with the narcissistic patient's demands for love, support and satisfaction in order to create and maintain the narcissistic transference.

Stern ***(1938)*** described the transference based on the ungratified and ungratifiable narcissistic needs of his patients, who often view the analyst as godlike, omniscient and omnipotent. As a result of this they feel secure and happy in the analysis as if they were in a Nirvana, but they remain without any insight. Stern stressed that a distorted perception of the analyst is quite real to these patients. The negative transferences have to be very carefully handled. When the analyst changes in the patient's eyes into a hostile or a cruel object, the patient often comes near to a psychotic state in the transference situation. Because of the omnipotence of the good or bad imago which the analyst represents, anything savouring of criticism has a most disturbing effect on the patient, as the analyst then changes into a bad figure, and the patient easily withdraws. Stern observed that in the narcissistic transference the patient never identified himself with the analyst but only with the concept of him produced by a process of projection of his own ego ideals. He particularly emphasized the sense of omnipotence with which the patient endows both the ideally good and excessively bad imagos which he projects on to the analyst.

Cohn *(1940)* examined the narcissistic phenomena in the transference in greater detail. He believes that the transference in general may be regarded as a narcissistic phenomenon and he regarded the transference of the narcissistic neurosis as simply of a primitive and rudimentary type. He observed that in the narcissistic transference there is often a serious difficulty in distinguishing between subject and object, and that this problem is caused by the mechanism of projection. He relates the processes of incorporation, expulsion and projection to organic fixations, which he thinks should be made conscious because they appear magnified as long as they are not evaluated by the conscious mental apparatus. He gives a number of clinical examples of the narcissistic transference; for example, in a depressive patient the analyst was treated as if he was the patient's own stool. This was one of the reasons why he could not distinguish between himself and the analyst. During the analysis it became apparent that the patient had not only projected his faeces and his anal sensations on to the analyst but also his own penis and in this way had lost it himself. In discussing a case of schizophrenia, he described a girl who seemed only interested in a book which she was tearing into little shreds. One day she suddenly attacked the analyst violently as if she were going to try to pull him to pieces. She said to him: 'Don't leave me, I have concentrated on you entirely.' Then she dropped back into her stupor and, he adds, the analyst into his ignorance. The analyst described that he had not realized at that time that the patient had been concentrating on him and not on the book. He is now aware that there had been a transference on a very primitive level. In most of his clinical examples he stressed the use of the mechanism of projection in the narcissistic transference. The importance of the mechanism of projection and the confusion of subject and object in the narcissistic transference was stressed by many later workers with psychotic patients (Searles, Rosenfeld, Bychowski and others).

Bullard, Federn, Fromm-Reichmann and others described very intense transferences in dealing with psychotic patients. Bullard *(1940)* said that in the psychotic there are profound swings of transference which are in a sense similar to those of the neurotic, but so intense

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and so carefully concealed by a mask of indifference or hostile suspiciousness that many analysts believe that the analysis of psychotic patients is impossible. Bullard stressed overt and concealed anxiety in psychotic patients and gave details of how to deal with this problem. When these anxieties were not clearly understood and brought to the surface, they threatened the continuance of the analysis and markedly affected the existing trend of rapport. He also mentioned that the intense, often paranoid hostility of the psychotic may be indicative of anxiety and may have a defensive purpose. He gave case material to illustrate a strong negative paranoid transference in which the patient threw things at him and insisted that the analyst was torturing him. He found that even such severe negative transferences can lessen markedly when the analyst is aware of the real cause of the patient's anxieties so that the patient feels better understood. Bullard *(1960)* described in greater detail the analytic approach to severely paranoid patients in a hospital setting. His patients appeared to have no insight and rejected therapy at the beginning. Bullard accepted the patient's paranoid attitude as a basis for starting treatment and did not attempt to create a positive transference artificially, which he feels would be a serious drawback to effective therapy. Bullard's contributions are particularly important because in contrast to many therapists dealing with psychotics he illustrated that the negative transferences of the psychotic can be understood and analysed in a therapeutic setting.

Federn treated psychotic patients at the begining of the century and made a very detailed contribution to the subject *(1943)*. He found that psychotics form a transference, but this is quite unstable and he therefore employed a different method from that with neurotic patients. He emphasized that in approaching psychotic patients we should remember that these patients are accessible to psychoanalysis because first they are still capable of transference; second, one part of the ego has insight into the abnormal state (but this is not a constant factor); and third, a part of the personality is still directed towards reality. The psychotic is eager to make transferences with both the healthy and the disordered parts of his ego.

The transference of the psychotic part of the personality is dangerous and can lead to aggression and slaughter as well as to deification of the object. ... Both aggression and deification can put an end to any contact with the analyst because of deeply rooted fears.

In comparing the treatment of the psychotic and neurotic Federn said that in psychosis normal resistances have broken down and have to be re-established by psychoanalysis. In order to re-establish the resistances in the psychotic, Federn advised that one has to abandon the usual psychoanalytic technique.

First abandon free association, second abandon analysis of the positive transference, third abandon provocation of transference

neurosis, because it quickly develops into a transference psychosis in which the analyst becomes the persecutor. Fourth, abandon the analysis of resistances which maintain repression. Phobias are left undisturbed because they protect against deeper fears and conflicts. ... In analysing the psychotic regression must not be increased.

He emphasized that the most important condition which should be considered in every psychoanalytic treatment of psychosis is the establishment of a positive transference, which must itself never be dissolved by analysis, and an interruption of the treatment when the transference becomes negative. Mainly for this reason Federn is emphatic that no psychoanalysis of psychotics can be carried out without a skilful and interested helper, preferably a woman, to take care of the patient between sessions and particularly during periods of negative transference. In discussing the ambivalence of the psychotic and the way its shows itself in the transference Federn stressed that the analyst has to realize that ambivalence is replaced in the psychosis by two or more ego states. These split ego states alternate in their strength and with them alternate the positive and negative transference to the analyst. Federn advised that, in psychosis, the therapist should slow down and even try to stop spontaneous delivery of still unconscious mental complexes because one does not want to face any increase of the psychotic disorganization until the ego has been re-established within its normal boundaries. In his treatment of psychosis Federn relied on that part of the patient which is still in touch with reality and external objects, the remnants of the normal ego. In describing his attitude to the patient he said:

The psychoanalyst shares the acceptance of the psychotic's falsifications as realities. He shares his grief and fears and on this basis reasons with the

patient. When convinced that by this procedure the patient feels himself understood the analyst presents the true reality as opposed to falsification. He then confronts the patient with his actual frustration, grief or apprehension, and connects this with the patient's deeper fears and conflicts and frustrations.

An important factor in Federn's technique is the conscious education of the patient in connexion with changes in his ego boundaries. He shows the patient, for example, that because of certain ego boundaries having lost their cathexis ideals, thoughts and memories are experienced as real and cease to be mere thinking. He stressed that the patient is able to learn to distinguish those ego boundaries with normal cathexis from those with cathexis withdrawn. He believed, contrary to Freud, that the loss of reality is a consequence of and not the cause of the basic psychotic deficiency. Federn made a detailed study of latent psychosis. He noticed that latent psychotic patients become openly psychotic during their psychoanalytic treatment. He was convinced that psychoanalysis often fosters the onset of psychotic depression and mania. In such situations he advised the immediate interruption of the free association method. He himself learnt to avoid the wakening of a latent psychosis and he became eager to take over those patients whose psychosis had been precipitated by the psychoanalysis of other analysts, and he mentioned that many patients were sent to him by former patients and by Freud himself.

Federn's contribution to the treatment of psychosis is of particular historical interest for us as he was one of the first analysts to treat psychotics with psychoanalytically orientated psychotherapy. Another point of interest is Federn's concentration of psychotherapeutic effort on the psychotic ego which he studied in detail, discussing in particular the splitting into healthy and psychotic parts, an observation which was taken up by Freud in the *Outline*. It is interesting that Federn held the view that neither the transference psychosis nor the negative transference of the psychotic could be influenced by psychoanalytic therapy.

It will have become quite clear that Federn made no attempt to treat the psychotic part of the patient's personality. His method of treatment was devised to suppress or, as he called it, to repress the psychotic productions which were overwhelming the patient's personality. It would perhaps be more appropriate to describe Federn's treatment as an attempt to help the patient to split off and to deny the psychotic parts of the self which had temporarily overwhelmed the more healthy part of the ego. The importance of this splitting process in the apparent recovery of the psychotic has been discussed by Freud in the *Outline*.

Up to the mid-1930s interest in the psychotherapy of the psychoses was very limited, but after about 1935 this interest increased markedly, particularly in the treatment of schizophrenia from a psychodynamic point of view. In America this stemmed largely from the work of Harry Stack Sullivan and in England from that of Melanie Klein.

Sullivan studied the interpersonal relations of his schizophrenic patients by creating a psychotherapeutic treatment unit in the Sheppard and Enoch Pratt Hospital. He found that even severely ill schizophrenic patients responded to what may be called a treatment group, where all the workers—doctors, nurses and helpers—aimed to assist the re-

orientation of the schizophrenic patient towards interpersonal relations. In fact, most of the patients seemed to recover in this setting and could be discharged. In many symposia and papers Sullivan stressed the psychogenesis of schizophrenia and the capacity of schizophrenics to form a transference. He disagreed with many psychoanalytic formulations. His basic developmental theory was expressed in these words:

There is no developmental period when the human exists outside of the realm of interpersonal relatedness. From the very early post-natal stage, at which time the infant first learns to sense approval and disapproval of the mothering person by empathy, some degree of interpersonal relatedness is maintained throughout life by eveyone, regardless of his state of mental health: therefore its disruption in the schizophrenic is only partial.

One of the analysts particularly inspired by Sullivan's work was Frieda Fromm-Reichmann, who started her work with psychotics under his guidance and developed her technique of treatment while observing and treating severe schizophrenic patients in the Chestnut Lodge Sanatorium over a period of more than 20 years. It is interesting to observe how her assessment of the schizophrenic patient gradually made her change her technique in dealing with them. In her first paper ***(1939)*** she emphasized that the patient who later develops schizophrenia has been traumatized severely at an early period

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when the infant lives grandiosely in a narcissistic world of his own. In this state he feels that his desires are fulfilled as a result of his magical thinking. She thought that the early traumatic experience shortens the period of narcissistic security, which sensitizes the schizophrenic patients towards the frustrations of later life. As a result of this the patient escapes the unbearable reality of his present life by attempting to re-establish the autistic delusional world of the infant.

Fromm-Reichmann described the extreme suspicion and distrust that such a patient evinces towards the therapist who approaches him with the intention of intruding into his isolated world and personal life. It takes weeks and months of testing of the therapist until the patient is willing to accept him, but after this his dependence on the therapist is very great, though he remains extremely sensitive about it. Whenever the analyst fails the patient, it results in a severe disappointment which is experienced as a repetition of previous frustrations, and leads to outbursts of intense hatred and rage. Following these observations, Fromm-Reichmann recommended that the treatment of the schizophrenic must begin with a long preparatory period of daily interviews. As the treatment continues, the patient is neither asked to lie down nor to give free associations. Nothing matters except that the analyst permits the patient to feel comfortable and secure enough to give up his defensive narcissistic isolation and to use the physician for resuming contact with the world. The analyst's function is seen as trying to understand and to let the patient feel that he does, without attempting to prove this by giving interpretations because the schizophrenic himself understands the unconscious meaning of his productions better than anyone else. The analyst gives evidence of understanding by responding cautiously with gestures or actions appropriate to the patient's communication. Altogether she recommends as a basic rule for the treatment of schizophrenics an atmosphere of complete acceptance. It is quite clear that, in this first period of therapeutic experimenting with schizophrenic patients, Fromm-Reichmann worked with a treatment approach based on the developmental theory of narcissistic injury which is identical to the one advocated earlier by Pearce Clark and that the positive relationship to the analyst is fostered to imitate an early omnipotent magical infant–mother relationship. This fostering of the positive relationship is reminiscent of Federn's recommendation of promoting a positive transference and avoidance of frustrations leading to negative transference reactions.

In her later papers ***(1948)***, (1952), (1954) Fromm-Reichmann revised and criticized her earlier approaches. She said:

Psychoanalysts used to approach the schizophrenic with the utmost care and caution. We assumed this to be the only way of making it possible for him to overcome his deep-rooted suspicious reluctance against reassuming and accepting any personal contacts, including those with the psychoanalyst.

She now criticized this approach as this type of doctor–patient relationship addressed itself too much to the rejected child in the schizophrenic and too little to the grown-up person before his regression. She also felt that this approach of unmitigated acceptance may be experienced by sensitive adult schizophrenics as condescension or lack of respect on the part of the analyst and may be interpreted by the patient as a sign of anxiety on the part of the therapist. She now recommended that the investigation of the doctor–patient relationship and its distortions should be included in the therapeutic process. In other words, the analysis of the transference which was formerly strongly

criticized was now fully recommended. She also criticized the previous cautiousness in her therapeutic endeavours; she expressed the opinion

that much valuable time had been lost by waiting too cautiously until the patient was ready to accept one or another active therapeutic intervention.

She also recommended more detailed investigation of the schizophrenic symptomatology and the schizophrenic productions; and thus follows Sullivan's direction, adding that according to him

the psychodynamics of manic illness including the schizophrenic manifestations can be understood as the result of an expression of unbearable anxiety and at the same time as an attempt at warding off this anxiety and keeping it from awareness.

In 1954 Fromm-Reichmann discussed the devastating effect of schizophrenic hostility on the patient's own personality and connected it with states of autism and partial regression.

This has led to a therapeutically helpful reformulation of the anxiety of schizophrenic patients as an

outcome of the universal human conflict between dependency and hostility which is overwhelmingly magnified in schizophrenia.

She discussed the resentment or violence with which the infant and child ('the bad me', as Sullivan called it), and later the schizophrenic patient, respond to the early damaging influences of the 'bad mother' as *he* experienced her. This explains why schizophrenic patients are more concerned with their own status as dangerously hostile people than with the damage which may be done to others who associate with them. In describing the schizophrenic conflict about dependency, she discussed the tension between dependent needs and longing for freedom. The fear of closeness is tied up with anxiety about their secret hostility against persons whom they value and depend on. This, she emphasized, must be worked through in the transference.

In her paper 'Psychotherapy of Schizophrenia' ***(1954)*** she stressed the importance of the non-psychotic part of the personality, and says,

we try to reach the regressed portion of their personalities by addressing the adult portion, rudimentary as this may appear in some severely disturbed patients.

This adult part is trained to join the psychoanalyst in his therapeutic endeavours. Even in her later work Fromm-Reichmann is reluctant to use more than minimum interpretations. Her therapeutic work relied greatly on guiding and directing the patient to a dynamic understanding and insight into his illness. It is interesting that Fromm-Reichmann was able to correct her 'fallacy' of concentrating in the treatment of schizophrenia on becoming a kind of ideal mother to the regressed schizophrenic patient. In her later work she concentrated on examining the conflicts and psychotic productions of the schizophrenic patient in the transference situation which brings her work in many ways closer to the researches of analysts in England. (See Segal, Bion, Rosenfeld and others.)

Searles, another member of the Washington group of analysts, made very detailed contributions to the treatment of schizophrenic patients while working for over 13 years at the Chestnut Lodge Sanatorium. Some of his papers such as 'Dependency Processes in the Psychotherapy of Schizophrenia' ***(1955)***, were written in close cooperation with Fromm-Reichmann. He stressed that difficulties arise in the transference situation through projections. The analyst is perceived as hostile and rejecting because of the patient's own frustration and anger. He described the resistance against dependence because it means giving up phantasies of omnipotence. The patient defends himself against his dependency by projecting his dependency needs into the analyst. As a result of this he fears the therapist's demands on him and becomes competitive and contemptuous. In a later paper (1963) he described the transference problem in more detail. He believed that

the transference of the schizophrenic is expressive of a very primitive ego organisation, comparable with that which holds sway in the infant who is living in a world of part objects.

He described three tasks which the therapist should perform. First, 'the therapist must become able to function as a part of the patient.' Secondly, he must be able to foster the patient's individuation out of this level of relatedness, the level which has been described 'by Kleinian analysts as being a transference phase dominated by projective identification on the part of the patient'. The therapist's third task is to discern and make interpretations concerning the patient's now differentiated and integrated whole object. This gradually transforms the patient's transference psychosis into a transference neurosis. Searles stressed the importance of a phase of therapeutic symbiosis where he regards verbal transference interpretations as contraindicated. He explained that the patient deep in chronic schizophrenia is not able to employ or even hear verbal communications. In this phase the patient uses the analyst as his own ego and has not sufficient ego functioning to understand interpretations, and he projects into the analyst a

variety of part-object transference roles, which the therapist must be able to endure and eventually enjoy. Through identification with the therapist who can endure his primitive object relations, the patient ultimately develops ego strength. In examining the transference in this symbiotic phase he said that it is astonishing to discover to what extent the patient is relating to himself or, more accurately, to a part of himself as an object. Searles does not discuss the splitting of the ego or self in detail, but his observations illustrate to what extent he has observed processes which have been described by other analysts either as narcissistic transferences or splitting and projections of part of the

self into objects. He also studied the concreteness of the schizophrenic patient's thought processes which lead to transference difficulties; for example, the therapist may be experienced by the patient not as like his father or mother, but concretely as the father or mother.

Searles examined the schizophrenic transference in admirable detail and has become aware of the importance of projection and projective identification in the transference. I think, however, he is seriously mistaken in his belief that the analyst should enter into the symbiotic transference as a state of mutual dependence, in which the analyst feels as dependent on the patient as the patient on him and often expresses his feelings of love and hate quite freely to the patient. I feel that Searles, who has trained himself to make elaborate use of his countertransference feelings, is sometimes carried away by them and does not sufficiently acknowledge or recognize the patient's projected desires for a mutual relationship with the analyst which eliminates the differences between child and adult. I would regard Searles' behaviour as acting in with the patient, instead of analysing this most important conflict in psychotic patients, their difficulty in depending on an adult who is then felt to be superior, and their resentment and attempts to reverse the infant–parent relationship or attempts to seduce the analyst into a mutually dependent position or push him out of his legitimate role. In my experience this acting in does not lead to ego strengthening, but increases the existing ego weakness of the psychotic patient.

It is, of course, impossible to discuss all the contributions to the treatment of psychosis and I shall now only briefly discuss Stone's view of the psychotic transference and Edith Jacobson's work with psychotic patients. Stone ***(1954)***, in contributing to the treatment of psychotic conditions, emphasized that the transference love of the hysteric is different from the primitive phenomena of the narcissistic transference. The psychotic's transference is liable to invade or overwhelm his personality, just as his psychosis threatens to overwhelm his ego. Stone is aware that sometimes the sheer fear of the primitive intensity of their feelings forces some patients to remain detached, but where the transference does break through, insatiable demands may appear, or the need to control and tyrannize the analyst or, failing that, complete submission to him. Sometimes the transference may be literally narcissistic when the therapist is confused with the self or is like the self in all respects. He stressed both the primitive destructiveness and the need to experience the analyst as omnipotent and godlike, and he suggested that in the patient's phantasy of the analyst's omnipotence, guilt about primitive destructive aggression plays an important part. From his own experience one may speak with justification of 'transference psychosis'. In discussing the analyst's attitude, he suggested that the decisive factor is the ability to tolerate, over long periods and without giving up hope, the strains of the powerful, tormented and tormenting transference and the potential countertransference situation. It seems that Stone advised only a minimum change in the psychoanalyst's attitude, in fostering the positive transference, so that the patient would stand the strains of the hostile transference when it appeared. He did not believe that analytic treatment could be harmful in basically psychotic patients. Since he did not feel that there could be such a thing as a latent psychotic state liable to be uncovered. This is, of course, unlike the view of Federn. Unfortunately, Stone's views are not exemplified by clinical material.

Jacobson has contributed mainly to the treatment of manic-depressive states, but has also made an interesting contribution to the treatment of schizophrenic patients. She emphasized that, in the course of the analysis of the depressive, the analyst inevitably becomes the central love object and the centre of the depressive conflict. As the analysis progresses, the patient may develop even more serious depressive states, characterized by deep ego and id regressions. She suggested that depressives try to recover their own lost ability to love and to function through magic love from the loved object. When they fail to get such help from without, they may retreat from their love object and from the object world and continue the struggle within themselves. In her experience the treatment of the manic-depressive starts regularly in the depressive state because they usually do not come for treatment during the symptom-free interval, or in hypomanic or manic periods. The depressed patient tends to establish either an imme-

diate, intense rapport or none. She felt there is usually an initial spurious transference success lasting many months; then there is an ensuing period of hidden negative transference with corresponding negative therapeutic reactions; and third, there is a state of dangerous introjective defences and narcissistic retreat; and finally a phase of gradual constructive conflict

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solution. The most difficult period in the transference relationship is when the patient lives only in the aura of the analyst and withdraws from other personal relations to a dangerous extent. The transference phantasies assume an increasingly ambivalent sadomasochistic colouring, and the author stresses particularly the patient's exhausting sadomasochistic provocations. The patient may unconsciously blackmail the analyst by playing on his guilt feelings, hoping in this way to get the longed-for responses. Failing to do so, he will try to elicit from the analyst a show of power, strictness or punitive anger, serving the alternative purpose of getting support or relief from the relentless superego pressure. She believed that in periods of threatening narcissistic withdrawal the analyst may have to show active interest in the patient's daily activities and especially in his sublimations, as she illustrates in case material. She also stressed that the depressed patient needs a more understanding attitude on the part of the analyst, an attitude which must not be confused with over-kindness, sympathy and reassurance.

In *Psychotic Conflict and Reality* **(1967)** Jacobson explained that her treatment of schizophrenic patients was mainly with an ambulatory type and was designed to avoid severe psychotic regression. Psychotics tend to use the external world to prevent the dissolution of their ego and superego structures. She believed that Freud's observation that psychotics give up reality and replace it by a newly created phantasy reality occurs only if reality fails to lend itself to the patients' purposes and to help them in their conflict solution. She described that if psychotic patients are able to project a bad unacceptable part of the ego into suitable external objects by a process of projective identification, they manage to remain sane as long as they can control these objects. Jacobson is aware of the regressive narcissistic nature of the patient's relations to these significant objects, and the weakness of the boundaries between the psychic representation of these objects and their own self. In describing her analytic experience with one of these patients, she said that she permitted the patient to use her as he needed and she adapted her emotional attitudes and behaviour to his wishes for warmth, or closeness or distance.

I let him 'borrow' my superego and ego, regard and treat me as his bad id and his illness: project his guilt, his faults and weaknesses into me or turn me into an ideal of saintliness he needed.

From her description it is clear that the patient not only projected his problems into her, but was acting out in the outside world significantly during this time. She said that she avoided giving him deeper interpretations of his acting out in the transference or in outside life until he himself knew that the period of danger was over. She would then use the material he had previously brought for interpretations, which at such times would be surprisingly effective. It is clear from Jacobson's description that the treatment was not used to work through the patient's early narcissistic projective identifications in the transference situation, as she was afraid of the danger of provoking a psychotic breakdown. Jacobson's method, as described here, has a great deal in common with Waelder's earlier attempts at treating the narcissistic neurosis by producing a sublimation of narcissism by linking it with object libido.

In turning now to the history of the psychoanalytic treatment of psychotic patients in England we have to consider first of all the pioneer work of Melanie Klein, who through her analysis of seriously disturbed children and adults, investigated the earliest infantile levels of development. In 1935 and 1946 she described details of the object relations, mechanisms and defences of two normal developmental phases, which she called the 'depressive position' and the 'paranoid schizoid position'. The paranoid schizoid position takes up the first four to six months of life and the depressive position follows on. The working through of these positions extends over the first few years of life. She suggested that, in the paranoid schizoid position, anxiety was experienced predominantly as persecutory and this contributed to certain defences, such as splitting off good and bad parts of the self and projecting them into objects, which through projective identification became identified with these parts of the self. This process is basic for the understanding of narcissistic object relationships. She said that if development during the paranoid schizoid position has not proceeded normally and the infant cannot, for internal or external reasons, cope with the impact of depressive anxieties which originate in the depressive position, a vicious circle arises. For if persecutory fear and correspondingly schizoid mechanisms are too strong the ego is not able to

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work through the depressive position. This leads to regression and reinforces the earlier persecutory fears and

schizoid phenomena. Thus the basis is established for various forms of schizophrenia in later life. Another outcome may be the strengthening of depressive features, which may be the cause of manic-depressive illness later on.

Winnicott was influenced by Melanie Klein's earlier work, particularly that related to the depressive position and the manic defences. In 1945, in discussing the treatment of a dozen adult psychotic patients, he said that

no modification in Freud's technique was needed for the extension of analysis to cope with depression and hypochondria. It is also true according to my experience that the same technique can take us to still more primitive elements, provided of course that we take into consideration the change in the transference situation inherent in such work.

In referring to primitive pre-depressive relations he clearly indicated that he interprets them as they appear in the transference. By 1959 Winnicott had altered his views considerably, both in theory and in practice. He emphasized that psychotic conditions were caused by early environmental failure. He stated that

failure of the facilitating environment results in developmental faults in the individual's personality development and in the establishment of the individual's self, and the result is called schizophrenia.

As he regarded psychosis as a deficiency disease, he believed regression to the state of early infancy, which he called dependence, had now to be seen as a part of the capacity of the individual to self cure. In analysis 'regression gives an indication from the patient to the analyst as to how the analyst should behave rather than how he should interpret'. The analyst, through his behaviour, has to make up for the failure of the early environment. Winnicott's views are here identical both in theory and practice with those of Pearce Clark and Fromm-Reichmann's early experiments and recommendations ***(1939)***. In discussing the analyst's attitude to the patient during a transference psychosis, Winnicott emphasized that it is dangerous if the analyst interprets to the patient instead of waiting for the patient to discover things by himself. He feels that when the analyst is experienced through interpretation as a not-me (a separate object) he becomes dangerous because he knows too much. Fromm-Reichmann shared Winnicott's reluctance to use interpretations with psychotic patients. However, as I have pointed out, she later criticized her early tendency to maintain a very careful waiting and protecting attitude to her psychotic patients. She found this not only unnecessary but damaging because of the over-emphasis on the patient's infantile helplessness.

While there were some analysts such as Winnicott and others who did not continue the application of Klein's work to the schizophrenic processes, others, such as Rosenfeld, Segal and Bion, were encouraged, particularly by her work on schizoid mechanisms, to treat schizophrenic patients by psychoanalysis.

Rosenfeld ***(1947)*** described an ambulatory analysis of a schizophrenic state with depersonalization. For some time he found the patient's narcissistic withdrawal and ego disintegration an insoluble problem until he became aware of her using certain schizoid mechanisms to defend herself against any painful feelings in the transference situation. She often lost all feelings and believed she had lost herself, experiences which could be traced to a process by which parts of her self were split off and projected into the analyst. She also had feelings of intruding inside the analyst and losing herself there, which gave rise to paranoid anxieties of being intruded by and overwhelmed by the analyst. The patient's narcissistic withdrawal had therefore been partly a defence against these paranoid fears and partly a defence against closeness because of her fears of intrusion.

In 1950 Segal made history by treating a hospitalized acute schizophrenic patient by psychoanalysis, which retained the essential features of the classical method. Even in the acute hallucinated state she interpreted the patient's defences and material with the emphasis on the negative and positive transference. In contrast to Federn, she analysed all the important resistances and interpreted unconscious material at the level of the greatest anxiety. She emphasized that progress in her patient was achieved only by making the patient aware of what had hitherto been unconscious. She found that schizophrenics often tolerate in their ego thoughts and phantasies which would probably be repressed in a neurotic, but at the same time they repress the links between phantasy and reality and these links have to be interpreted. She also illustrated that repression often referred to later infantile material of a depressive nature, while consciously very primitive archaic material

was being produced in the analysis. In describing the transference at the beginning of the analysis, she stated that the patient was full of persecutory fears and he needed an unchanging good figure, which he tried to believe he had found in the analyst. However, to preserve this belief he had to use all his defences. She said:

If I frustrated him he would deny that frustration and split me into a good and bad figure. The bad figure would be introjected as hostile voices or reprojected into the hospital doctors.

At the beginning of the treatment the patient was detached from reality and unable to grasp the nature of the

treatment and constantly demanded reassurance. Her aim was to retain the attitude of the analyst even without the cooperation of the patient. She said:

to achieve this I had first of all to make him accept my interpretations instead of the various gratifications he wanted. ... I tried to show him in every interpretation that I understood what he wanted from me, why he wanted it at that particular moment. I also followed most interpretations of that kind with an interpretation of what my refusal had meant to him.

She gradually understood that the patient's constant need for reassurance was aimed at making the analyst an ally against his persecutors which were particularly related to the doctors in the hospital. She gave illustrations of how she managed to bring the negative persecutory transference, split off on to the doctors in the hospital, into the transference situation. Segal discussed the controversy as to whether the analyst should reassure the very ill schizophrenic patient in a moment of crisis and when craving for reassurance as many of the analysts whom I have quoted would do; for example, Fromm-Reichmann, Searles, Federn, Pearce Clark and Winnicott. Segal is convinced that by giving sympathy and reassurance the analyst becomes, for the time being, the good object, but only at the cost of furthering the split between good and bad objects and reinforcing the patient's pathological defences so that later the negative transference becomes unmanageable. In this paper Segal pointed out some technical difficulties in the analysis of the acute schizophrenic patients due to their concrete thinking disorder, a process which she traced to difficulties in the patient's use of symbols. As a result of this, the patient often misunderstands interpretations as they are experienced as concrete threats and actions on the part of the analyst.

In 1952 Rosenfeld described the analysis of an acute hallucinated schizophrenic patient in hospital. He stressed the peculiarity of the schizophrenic object relation:

whenever the acute schizophrenic approaches an object in love or hate he seems to become confused with this object.

He observed that the schizophrenic impulses to intrude into the analyst with positive and negative parts of the self, and the defences against this object relationship, were typical of the transference relations of most schizophrenic patients. He also discussed the role of verbal interpretations. While acknowledging the importance of the analyst's intuitive understanding of the patient's communications, he thought that the analyst should also be able to formulate consciously what he has unconsciously recognized and to convey it to the patient in a form that he can understand.

This after all is the essence of all psychoanalysis, but it is especially important in the treatment of schizophrenics, who have lost a great deal of their capacity for conscious functioning, so that without help they cannot consciously understand their unconscious experiences which are at times to vivid.

In 1954 Rosenfeld said that he found

that the psychotic manifestations attached themselves to the transference in both acute and chronic conditions, so that what might be called 'a transference psychosis' develops.

He stressed that, in the acute schizophrenic state, the patient tends to put his self so completely into objects (during the analysis into the analyst) that there is very little of the self left outside the object. This interferes with most ego functions, including speaking and understanding words. It also inhibits the capacity to experience relations with external objects. The patient may have difficulty in speaking and may be confused, negativistic or withdrawn as a result of the severe anxieties related to this process and he may not be able to understand ordinary conversation. Rosenfeld emphasized

if we use interpretations to approach the patient and if our interpretations touch upon his anxieties

we shall get some response. There will either be a change in his behaviour or he will talk.

In this paper Rosenfeld developed the concept of the transference psychosis which had been introduced earlier by Federn ***(1943)***. However, Federn had been emphatic that the transference psychosis had to be avoided because it was unanalysable, while Rosenfeld emphasized the importance of recognizing the psychotic transference and working through it by means of interpretation.

Bion made important contributions to the psychopathology and treatment of schizophrenic patients from 1950. He emphasized that he did not

depart from the psychoanalytic procedure usually employed with neurotics, being careful always to take up both positive and negative aspects of the transference.

He looked for evidence of the meaning of the patient's communication in the patient's actions and verbal communication but also in his own countertransference reaction. He investigated both the language of the schizophrenic

and his disturbances in thinking. He stressed, for example, that the schizophrenic uses language in three ways: 'As a mode of acting, as a method of communication and as a mode of thought.' He clarified that the use of words and thought depended on the capacity for verbal thinking, which is often lost in schizophrenia through processes of severe splitting and projection so that the patient is only left with an embryonic capacity for it. In the analytic transference this capacity for verbal thought is often projected into the analyst, which leads both to the persecutory fears of the analyst who is believed to have taken it away, or the patient fears that he had lost it at an earlier stage of development which increases the need to regress 'to fetch it'. Lack of the capacity for verbal thought is felt by the patient to be the same thing as being insane. Bion gave a vivid picture of his analytic approach in describing the interchange of communication between patient and analyst. It illustrated the importance of the analyst's verbal interpretations in dealing with the schizophrenic's severe disturbances of speech and thought. In 1956 he contributed in greater detail to the understanding of the schizophrenic transference. He stressed the preponderance of the destructive impulses in schizophrenia, which are so great that even the impulses to love are suffused by them and turned into sadism. He also emphasized that there is a hatred of reality, as Freud pointed out, but Bion added to this the importance of the schizophrenic's hatred of internal reality and all that makes for awareness of it. Derived from these two basic difficulties there is an unremitting dread of imminent annihilation. In discussing the transference with the analyst, which he described as thin but tenacious, he said: 'The relationship with the analyst is premature, precipitate and intensely dependent.' When the patient broadens it under pressure of his life or death instincts two concurrent streams of phenomena become manifest.

First projective identification, with the analyst as object, becomes overactive with the resulting painful confusional states such as Rosenfeld has described. Second, the mental and other activities by which the dominant impulse, be it life instincts or death instincts, strives to express itself, are at once subjected to mutilation by the temporarily subordinate impulse. Driven by the wish to escape the confusional states and harassed by the mutilations, the patient strives to restore the restricted relationship: the transference is again invested with its characteristic featurelessness. Oscillation between the attempt to broaden the contact and attempt to restrict continues throughout the analysis.

In 1957 he made important contributions to the therapy of schizophrenia by differentiating the psychotic from the non-psychotic parts of the schizophrenic personality. He emphasized particularly the role of projective identification in the psychotic part of the personality as a substitute for repression in the neurotic part of the personality.

The patient's destructive attacks on his ego and the substitution of projective identification for repression and introjection must be worked through.

SUMMARY

In this paper I have tried to show the main trends in the development of the treatment of the psychoses. After Freud's pessimism about the analysis of psychotic patients, due to his belief that they formed no transference, two main trends in the approach to the treatment of psychotics have appeared. There were those who believed that the narcissism of the psychotic patient presented a complete obstacle to analysis unless the analyst changed his usual analytic attitude. Analysts who held the view that the narcissism of the psychotic patient was caused by an environmental failure attempted to provide the patient with a new and better mother in the form

of the analyst, to make up for the deficiency of the early environment. Exponents of this approach were particularly Pearce Clark, Fromm-Reichmann in her early period, and Winnicott in his later work. Searles' approach is closely related to this, as he recommends the analyst's intense involvement with the psychotic patient, particularly in the symbiotic phase of the analysis. Waelder and Jacobson have also altered their analytic attitude. They do not analyse the transference but maintain a predominantly positive one and use it as a vehicle to sublimate the patient's narcissism or psychosis by relating it to object libido and the external world. Federn similarly encouraged the positive transference and avoided any analysis of transference manifestations. However, he differed from Waelder and Jacobson by training the patient to repress or split off the psychotic parts of his personality. Searles and Fromm-Reichmann in her later work differ from others in this group in so far as they analyse both the negative and the positive transference.

The second group of analysts attempted to deal with the narcissism and other psychotic manifestations of the patient by the classical psychoanalytic approach with only minor changes. First came Abraham, who found that the narcissistic defences of his patients were markedly diminished by interpretations. Then Stern, Cohn, Stone and Bullard described characteristics of the positive and negative transference of psychotic patients, which they felt

could be analysed by verbal transference interpretations.

Segal, Bion and Rosenfeld stressed that no change in the analyst's attitude and only minor changes in technique were necessary, and that the psychotic productions attached themselves to the transference, which could be interpreted in both its negative and its positive forms to the patient. They also relied exclusively on interpretations to deal with the serious language and thought disorder of the schizophrenic patient, and saw these difficulties as part of the malfunctioning of the psychotic ego with its disturbed relationships to both external and internal reality and objects. The development of the treatment of psychosis over the last 50 years suggests that Freud's hope that some approach to the treatment of psychosis might become possible is now justified.