

PSYCHOANALYSIS AND PSYCHOSIS

Edited by

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INTRODUCTION

ANN-LOUISE S. SILVER, M.D.

Dexter Bullard, Sr., and Frieda Fromm-Reichmann began work together when the world was immersed in a war of massive proportions against an enemy in the grips of a psychotic leader. The rather tall and formidable Dr. Bullard, who could trace his American lineage back to the original settlers along the banks of the Charles River in Massachusetts, combined forces with a German Jewish immigrant four feet ten inches tall, and together this unlikely pair fought their common enemy, psychosis itself. Their teamwork resulted in an atmosphere of intense productivity and high morale at Chestnut Lodge.

The Lodge, a private psychoanalytically oriented hospital located in the "historic" area of Rockville, Maryland, now a suburb of Washington, D.C., has contributed significantly to the dynamic understanding of the hospitalized mentally ill. A review of some of the resulting publications (Fromm-Reichmann, 1950, 1959; Bullard, 1940, 1952; Searles, 1960, 1965; Cameron and Esterson, 1958; Cameron, 1970; Pao, 1969, 1973, 1979; Burnham, 1961a, b; Burnham et al., 1969; Kafka, in press; Will and Cohen, 1953; Will, 1958, 1964, 1965) conveys the intensity with which the staff explored the dynamics of the disorders under treatment and of the patterns of interaction between doctor and patient. A review of the transcripts of the staff conferences transmits a mood of heroic battle. Although false politeness and the avoidance of hurt feelings had no place at these conferences, there was nonetheless a high degree of mutual respect in the way staff members dealt with one another. And although the staff clearly was aware that they were not

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producing miraculous results, there was a dedication to perseverance and a high degree of realistic hopefulness.

Fromm-Reichmann set forth the tenets of her philosophy in the introduction to her book, *The Principles of Intensive Psychotherapy*, where she stated:

Emotional difficulties in living are difficulties in interpersonal relationships; and a person is not emotionally hampered, that is, he is mentally healthy to the extent to which he is able to be aware of, and therefore to handle, his interpersonal relationships. In stating this and, by implication, defining psychiatry and psychotherapy as the science and art of interpersonal relationships, I not only wish to say that a person is mentally healthy to the extent to which he is able to be aware of and to handle his overt relationships with other people. But I also wish to refer to a much more far-reaching fact. We can understand human personality only in terms of interpersonal relationships. There is no way to know about human personality other than by means of what one person conveys to another, that is, in terms of his relationship with him. Moreover, the private mental and emotional experiences, his *covert inner* thought and reverie processes are *also* in terms of interpersonal experiences . . . When the experience is a psychotherapeutic one, it is the interpersonal exchange between the patient and the psychiatrist as a participant observer which carries the possibility of therapeutically valid interpersonal investigation and formulation [p. xiv].

Dexter Bullard, Sr. outlined the history of the Lodge in an unpublished address to the Ontario Psychiatric Association on February 2, 1968. To paraphrase:

His father, Ernest Bullard, was a horse-and-buggy country doctor in Waukesha, Wisconsin, who became interested in politics and was elected to the state legislature. He made the acquaintance of Governor Robert La Follette, Sr., and was subsequently appointed superintendent of the Mendota Hospital for the Insane, across the lake from Madison. He bridled at being a government appointee, had a falling out with the governor after two years, and went into private practice in Milwaukee, later becoming head of the department of neuro-

logy and psychiatry at Marquette. He began to look around for a hospital of his own, spending two summers going up and down the East coast with his family in search of a suitable location. He favored the Washington area, reasoning that were there to be a depression, the nation's capital would be more secure than elsewhere.

In 1908, he discovered the Woodlawn Hotel, which had been abandoned for two years, and began refurbishing it, establishing a rest cure asylum typical of the times. He was not analytically oriented, and teased his son Dexter Sr. about his analytic interests. From 1910, when the Lodge opened, until 1917, when Dexter Sr. went to college, Dexter Sr. spent much time with the patients, who first served as his babysitters and later as his companions with whom he played cards and croquet, took walks, etc. This continuing and close contact with hospitalized individuals led to his firm conviction that psychotics could be treated in insight-oriented therapy. Dexter Sr. graduated in 1923 from the University of Pennsylvania Medical School, the only one in his class interested in psychiatry as a career, and after an internship in Hawaii, he did his residency at the Boston Psychopathic Hospital. Meanwhile, Ernest Bullard ran Chestnut Lodge alone, working seven days a week. When he had a coronary, Dexter Sr. returned to Rockville and took over as medical director. In 1927, Dexter Sr. married Anne Wilson. Mrs. Bullard, who still lives at Rose Hill at the Lodge, ran the hotel aspects of the place and planned the now magnificent landscaping.

In 1931, Ernest Bullard died. Dexter gave himself five years to determine which direction the Lodge would take. In 4½ years he knew it would go the psychoanalytic route, applying Freudian theory to the treatment of psychosis. Dexter Sr. saw close parallels between Freud's writings on dreams and the schizophrenics' communications, in particular in catatonic excitement, and he hoped that the careful interpretation of these communications would result in reducing the patients' profoundly disorganizing anxiety.

In 1933, he engaged the first analytically trained psychiatrist, Marjorie Jarvis. They shared the work and soon found that the daily administrative details of patient management in-

truded on the analytic process. Telling a patient, for instance, that he or she could not go into town because of recent drunkenness might lead to the patient's retaliation by such measures as refusing to talk to the doctor. So they concocted the system of splitting the administrative and analytic functions, with each doing patient management for the other. This system, still in place at the Lodge, was first reported on by Morse and Noble (1942).

In 1935, Fromm-Reichmann was hired, though not without some initial resistance on Dexter Sr.'s part. Dexter was in personal analysis with Dr. Ernest Hadley, and was in a phase of negative transference at the time. Nothing Hadley said seemed right. In February, Hadley, who apparently had been called by Erich Fromm, asked if Dexter would be interested in having a middle-aged German-Jewish refugee come to the Lodge to work. He said absolutely not. Then in May, when both he and Jarvis started planning summer vacations, and there were no other psychiatrists on the staff, he asked Hadley if Fromm-Reichmann was still available. Hired as temporary summer help, Fromm-Reichmann arrived at the Lodge on July 1. Says Dexter Sr., "We fell in love at first sight, and she stayed until her death in 1957."

Fromm-Reichmann, nine years older than Dexter Sr., recorded her autobiography in taped interviews held about a year before her death. The transcript, which forms a chapter of this book, amply conveys her warmth, verve, and sparkling intelligence. It gives clear evidence that Chestnut Lodge became, to Fromm-Reichmann, a superb replacement for the institutions and relationships lost to her because of World War II. It may well have been "love at first sight" for her as well.

After Fromm-Reichmann's arrival, the staff grew gradually to include Bob Morse, Doug Noble, and David Rioch, then Mabel Blake Cohen. Between October 1942 and April 1946, Harry Stack Sullivan began coming out to the Lodge twice a week to conduct seminars in a leisurely question-and-answer format, with many digressions. The transcriptions of some of these meetings form the basis of *Clinical Studies in Psychiatry* (Sullivan, 1956). Fromm-Reichmann attended regularly, and frequently referred to Sullivan's remarks when discussing cases

in the Wednesday staff conferences, which at that time were much like traditional rounds. In 1942, Fromm-Reichmann became the first director of psychotherapy, and began recording these meetings. These transcripts document the development of the hospital's gradually evolving perspectives of treatment.

In 1948, Fromm-Reichmann and others initiated the system of "small groups," dividing the medical staff into groups of approximately eight members who met twice a week to discuss whatever clinical matter seemed most pressing. This system is still in place today, with the groups maintaining the same membership for three or four years before reconstituting. This arrangement gives members time to develop trust in each other and to collaborate with each other, after which they move on to work with others on the staff.

Increasingly, Fromm-Reichmann's comments became more instructional and the staff conferences more analytically focused. In 1952, the Lodge began training residents, who would come for their third year of training with the proviso that they would stay at least one additional year. These positions became highly sought after. Many of the residents were supervised by Fromm-Reichmann, usually for just one or two years, sometimes individually and sometimes with another staff member, the two alternating presentations of cases. Among those who joined the staff during those years as residents are some of the contributors to this book: Donald Burnham, Jarl Dyrud, John Fort, Robert Gibson, John Kafka, Clarence Schulz, and Harold Searles. Robert and Mabel Blake Cohen, Samuel Thompson, and Otto Will had completed residency training prior to their arrival.

Fromm-Reichmann had many invitations to speak, and wherever she went, she made a strong impression. Indeed, when she spoke in Topeka at the Menninger Clinic, Karl Menninger, trying to tempt her to join his staff, offered to build her a house. Dexter Sr. notes that "it took us about a week to put our carpenters to work to build the Frieda Fromm-Reichmann Cottage." It became her permanent home for the rest of her life, and it was there that she died. During the 1950s, Fromm-Reichmann traveled regularly, often weekly, to New York City, where she taught and supervised and was a founding

member of the William Alanson White Institute. She was also influential in the organization of the American Academy of Psychoanalysis, although she was in California during 1956, the year of its founding. Among her New York supervisees were Rose Speigel and John Schimel.

Both Mabel Peterson, former executive secretary at The Lodge, and Joanne Greenberg, author of *I Never Promised You a Rose Garden* (Green, 1964), a fictionalized account of her treatment by Fromm-Reichmann, commented on Fromm-Reichmann's military style, which persisted from her days as a major in the Prussian Army, when she ran a hospital for brain-injured soldiers. She did not walk but marched briskly, her back always straight and her head high, in soldierly fashion. At the military hospital she insisted that, for their optimal functioning, her medical staff and the brain-injured soldiers be cognizant of army codes. At the Lodge she was also a stickler, insisting that the staff be alert to the nuances of the patients' anxieties and their own countertransference.

From 1955, when she spent the year in Stanford, until her death two years later, Fromm-Reichmann rarely attended conferences, perhaps because of her increasingly incapacitating hearing deficit. When one reads her autobiographical transcript, one is struck by the counterphobic aspect of her choice of psychoanalysis as a career, for both her parents and other family members had suffered from severe deafness in their adult years. She had been gradually recovering from an enervating flu when, on April 28, 1957, she suffered a massive and immediately fatal coronary occlusion. She was sixty-seven years old.

Chestnut Lodge has changed dramatically since the 1940s and '50s. There are three times the number of patients and medical staff. Under the leadership of Dexter Bullard, Jr., who became the medical director of the Lodge in 1969, a separate adolescent division with an independent school has been established. In 1986, E. James Anthony became the adolescent division's first director of psychotherapy. In the adult hospital, Ping-Nie Pao, following Otto Will, served as director of psy-

chotherapy from 1967 until his death in August 1981, just two months before Dexter Sr.'s death on October 6, 1981.

Thomas McGlashan, director of research, has orchestrated an elaborate follow-up study of the patients treated at the Lodge between 1950 and 1975. The initial findings were reported in 1984 and 1986, but the data continue to supply information on many interrelated questions regarding diagnosis and prognosis. Changes in the adult hospital include an intricate outpatient program which is still evolving and which attempts to meet the needs of an ever-increasing outpatient population. New facilities will soon house the adult patients. The doctors will then have their offices in the main building, the former Woodlawn Hotel.

But the most dramatic change has come with the advent of psychotropic medication, whose use has altered the Lodge in both obvious and subtle ways. The place is far quieter. One rarely hears someone screaming redundantly in hallucinated discourse in a "quiet room." One rarely arrives on a unit to see a group of male psychiatric technicians reviewing their strategy before entering a seclusion room to secure a patient in cold wet-sheet pack—"You take the right leg, you take the left . . ."—or moves aside quickly in the stairwell as psych techs rush to a unit on which the emergency bell has been sounded. It is also rare to learn that a psychiatric technician has been injured during the staff's efforts to place a patient in cold wet-sheet pack so that the patient can meet with his or her therapist for their still-routine four or more full sessions per week. Assaults on therapists are similarly far less frequent. Unpredicted violence, disrobing, incontinence of urine and feces, and prolonged phases of mutism or refusal to eat are now far from commonplace.

With the marked diminution in frequency of these regressive symptoms, the ambience of the place has changed. One can keep potted plants around if they are not to become weapons. As they thrive, they lend a sense of dependability. Similarly, one can develop a library if one is rather confident that the books will not be ripped to shreds. Curtains, pictures, wallpaper, and other furnishings can age gradually, developing a patina of constancy.

For those who return to the Lodge after an absence of many years, these changes are startling. Morris Schwartz, for instance, co-author with Alfred Stanton of *The Mental Hospital* (1954), had last seen the Lodge's Main IV—the unit on which he had gathered sociological data for his book—in 1956. When he attended the 1985 Chestnut Lodge Symposium commemorating the fiftieth anniversary of the arrival of Frieda Fromm-Reichmann, he was eager to see the unit again, and braced himself for an onslaught of waves of nostalgia. He imagined himself thinking, "Yes! That's where such-and-such happened!" or "That still looks the same!" Instead, as he later said, he felt as if he were in an entirely new place. Nothing at all looked familiar. He felt that if a series of photographs of the current Main IV had been mixed in among pictures of places where he had never been, he would have been unable to identify them as the place where he had once had such intense experiences. He felt that the long and interesting conversation he had held during the symposium with one of the patients could just as well have been held with a member of the nursing staff. And when he sought out a patient he had first met in the 1950s, a patient who had required hospitalization continually during the intervening years, he was astounded by her significant improvement in mental functioning and by the intellectual sparkle of her remarks. Schwartz summarized his experience by saying that he felt that the place he encountered in 1985 was more like a college dormitory than like the Chestnut Lodge he remembered.

The increase in use of psychotropic medication was gradually effected during the years that Ping-Nie Pao served as director of psychotherapy, 1967 to 1981. While he did not address the question of medication in his book, *Schizophrenic Disorders* (1979), his theories have been applied to the use and misuse of medication (Feinsilver, 1983). After the introduction of medication, there was an initial, and inevitable, phase of adjustment during which the focus on the therapeutic dyad decreased. When a patient regressed, attention turned first to the medication as the agent of change, and only secondarily to the therapist-patient dyad, the complexities of therapist-administrator splits, and the interpersonal difficulties that were

so eloquently explicated in *The Mental Hospital*. Too often, from the therapists' view, members of the treatment team—usually the administrative psychiatrist and the nursing staff—suggested medication. In response, therapists often reacted with adamant rejection of the idea, or with pleas to wait some months longer.

A regular view expressed at staff discussions in the early years of medication was that the therapists were jealous of the power of the medication, and of the intimate and yet nonverbal relatedness of patient and drug. Jealousy aside, the introduction of medication raised issues which continue to be discussed. It is true that some therapists have seen the introduction of psychotropic medication as long overdue, and have often advocated one or another medication. But others feel conflicted about the use of these medications because they sense the drugs' power both to enhance and to detract from the interpersonal exploration.

Although medication is here to stay, Chestnut Lodge continues to adhere to the principles of psychotherapy enunciated by Fromm-Reichmann and Sullivan and many others. Our current director of psychotherapy, Robert A. Cohen, who was an analysand and a colleague of Fromm-Reichmann and a supervisee of Sullivan, has urged us repeatedly to study dispassionately the interplay of psychoanalytic psychotherapy and pharmacotherapy. In the weekly psychotherapy seminars which he chairs, he and others repeatedly demonstrated that analytically based dyadic work proceeds with the *same general pattern* of relatedness modes with or without medication. Thus today we still apply the same rules of treatment which were developed at a time when patients would let a doctor know instantaneously—through assault or mutism or catatonia—that they had lost hold of their fragile thread of trust because of something the doctor had said or done.

Psychotropic medication, it could be argued, has made poorer teachers of our patients. They cannot inform us of the disruptiveness of our mannerisms, styles of interpretation, or errors in understanding, for their greater cohesiveness allows for greater resilience and impulse control. It is clear, nonetheless, that the dynamic issues or core conflicts are still the same. Defenses such as projection, denial, grandiosity, splitting, and

intensification of hallucination must still be analyzed as they develop in the transference, with careful acknowledgment of countertransference phenomena. We need to study the writings of the analysts who worked with psychotic patients during the premedication days, and never lose sight of the underlying conflictual dynamisms in our patients and ourselves. Otherwise, we will be left with little to offer our patients but consolation, behavior modification, and a dependency on external agents.

Without the kind of insight which only develops through interpersonal analytic work, patients cannot gain a sense of mastery over their chaos. But when they are able to resolve the chaos through evolving shared insight and trust, they have something of more personally lasting significance, something which strengthens their sense of autonomy and their pride as a collaborator. Fromm-Reichmann's *Principles of Intensive Psychotherapy* is still available in a paperback edition, is still stocked at medical school bookstores thirty years after its publication, is still standing as an invaluable introduction and guide for those working with the hospitalized mentally ill.

The present book offers new papers by members of the analytic community who have contributed significantly to our understanding of the psychotic process as part of the human condition. We hope that reading their papers and contributions will inspire our younger colleagues to delve into a detailed exploration of these contributors' earlier writings. Trained during a time when hope was exceedingly high that medications would prove curative and when studying the intricacies of intensive psychotherapy had been considered by many to have become obsolete, these younger colleagues may often be unaware of the rich drama occurring in their own and their patients' unconscious as they proceed with their interviews. They are then left with a feeling of uneasiness which can convert readily to boredom and hopelessness. If this trend is not reversed, something very precious may be lost.

The present collection of papers is an outgrowth of the thirty-first annual Chestnut Lodge Symposium, which commemorated the fiftieth anniversary of the arrival of Frieda Fromm-Reichmann. The presenters included Lawrence Kolb, Ruth W. Lidz, Laurice L. McAfee, Harold Searles, Ann-Louise

S. Silver, Alberta Szalita-Pemow, and Otto Will. Robert Cohen who collaborated closely with Silver in the organization of the conference, delivered a posthumous paper by Samuel Thompson.

Because of time restrictions, many distinguished colleagues who had worked with Fromm-Reichmann as patients, supervisees, collaborators, or supporters could not be invited to read papers at this one-day conference. Instead, they were asked to contribute papers to this collection, with the suggestion that they write something which they felt Fromm-Reichmann would have enjoyed reading. Some of the contributors have offered, in addition to their papers, short sections of personal reminiscences and remarks which orient the reader to their connection with Fromm-Reichmann. Taken together, these papers convey a philosophy and ambience of scholarly and dedicated optimism that continues to enrich this extremely challenging work.

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Frieda and her sisters—
Anna, Frieda and Greta Reichmann



Frieda as a teenager



Frieda and the obstetrics staff—
medical school years



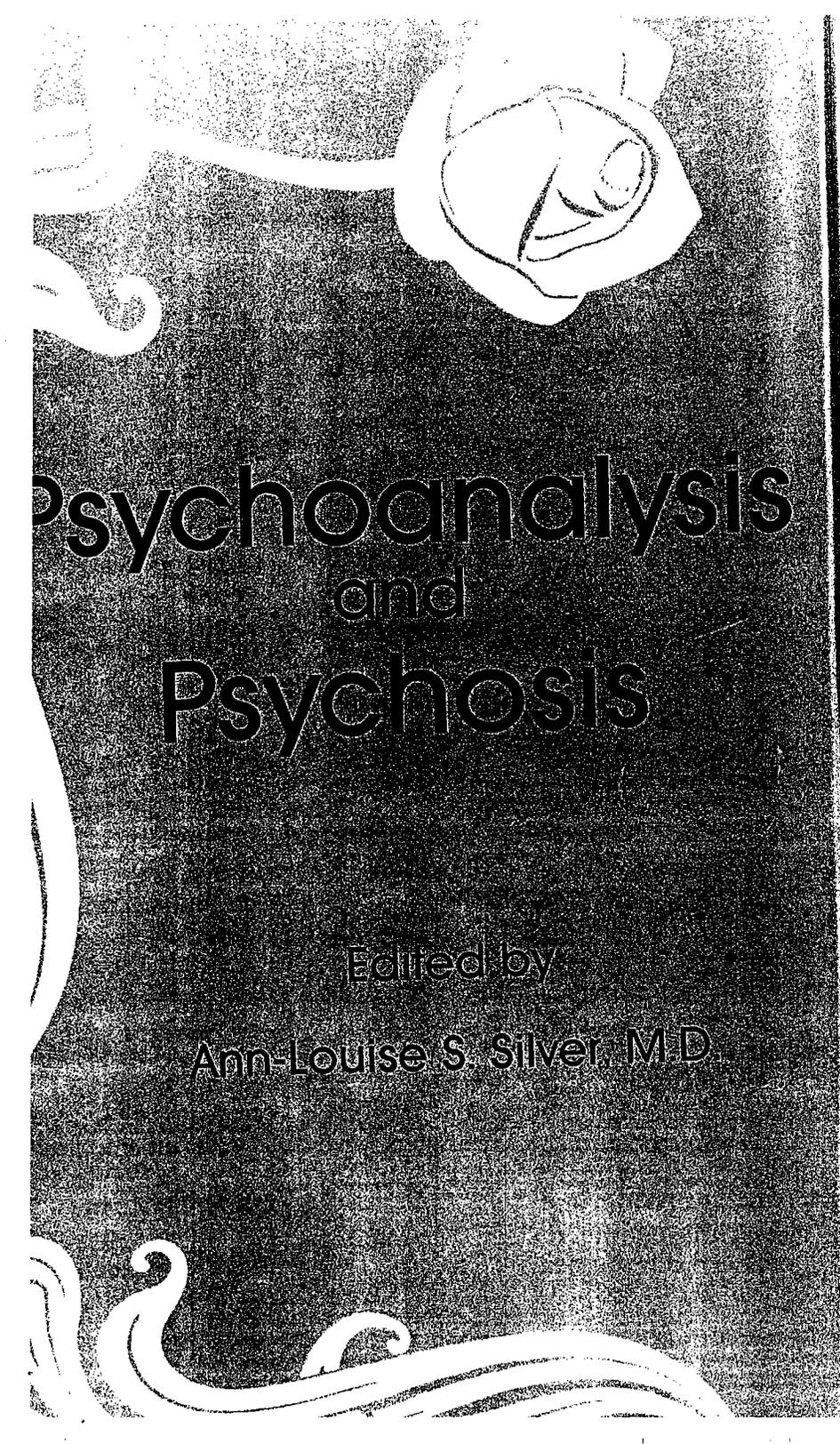
Frieda in medical school



Fromm-Reichmann's sanatorium
in Heidelberg, Germany



Georg Groddeck



Psychoanalysis and Psychosis

Edited by

Ann-Louise S. Silver, M.D.

I

FROMM-REICHMANN'S CONTRIBUTIONS AT STAFF CONFERENCES

ANN-LOUISE S. SILVER, M.D. and POLLIANNE CURRY FREUER

I asked what helped towards recovery . . . One thing which she considered very helpful . . . , as she began to get better, I made a remark, and I don't remember in what connection, to the effect that even if she would be well, life would not be a rose garden, but I hoped she would come to the point that she would be strong enough to stand the times when it wouldn't be a rose garden and enjoy the times when it would be. [She said,] . . . "I didn't believe you at the time. I was quite sure that if I really got well, . . . then it would be a rose garden all the way through. But the fact that you said it to me and you obviously believed it gave me the feeling that you really took me seriously and really had confidence in me as a human being. And that's why it meant so much, even though I didn't believe a word."

Frieda Fromm-Reichmann (Staff Conference)

In this chapter, we will report on some of Fromm-Reichmann's contributions to the weekly two-hour-long staff conferences. Her straightforward style of speaking at these conferences was similar to her writing style and evolved with her gradually increasing confidence, stature, and maturity. She was not one to dazzle her listeners with involved theoretical speculation; neither would she paraphrase the writings of others. She simply wanted to see the work done well and carried to a satisfactory completion. She encouraged the staff to stay with the task. If one were to stop midway, one should know the reasons why. Strong feelings such as discouragement, contempt, revulsion, or murderousness could be the very essence of countertransference which, if effectively explored, could provide the insight necessary for effective interpretation. Alternatively, these feel-

ings could provide data necessary for the next therapist's potentially more effective work with that patient. In some way, all her comments related to the exploration of the interrelationship of anxiety, hostility, and loneliness in the patient, the therapist, and other staff members. The more the patient could convey the extent of his or her anguish and confusion, the greater were the chances of recovery.

Fromm-Reichmann *knew* that psychoanalytic therapy was a powerful instrument for profound change. The problems were in how to use it, how to teach using it, and how to improve it. She taught one lecture course per year at the Washington School of Psychiatry, supervised analysts either individually or in pairs or small groups, treated some in training analyses, and led research seminars. In addition, she participated in the two-hour weekly staff conferences which were attended initially only by the medical staff, and later came to include the entire professional staff.

The title of her book, *Principles of Intensive Psychotherapy*, was thoughtfully chosen by her to emphasize the importance of principles, as she herself noted in her autobiographical taped recording. She was intense and intensely dedicated. Many people, both colleagues and patients, have commented on her full use of facial expressions and lively hand gestures to enhance and embellish her comments. She did not try to conceal her emotional reactions to what she heard. With so much nonverbal communication we may sometimes fail to grasp the full flavor of her intent and affect.

Fromm-Reichmann was never falsely polite. This authenticity extended to everyone—patients, staff, and her boss, Dexter Bullard, Sr.—as is illustrated in the following vignette:

Dr. Bullard: He has told me that everybody tells him he was just born to be a priest. The greatest difficulty I have is of following through from one point to the next and tying it up. I would say we fight just about half of the time. I will say, "I do not believe that is true," and he will say, "Doctor, you are a liar." His feeling of resentment and bitterness is genuine and his feeling that I really want to help him is genuine, but where they collide is only confusion.

FFR: You are dealing with an utterly lonely child and

to become a priest meant having lots of people loving you. And that was the one way he could get love which he wanted. Now you tell him you do not trust that business, which is to throw him back to his loneliness.

With such forthrightness, her praise of a therapist's work was treasured as absolutely sincere.

Although Fromm-Reichmann encouraged therapists to recognize and acknowledge a patient's unspoken needs, she became clearly irritated when they offered unwarranted reassurance. She also had little patience when therapists covertly directed a patient to hide his or her pathological aspects from them. And she had only slightly more tolerance for a patient who filled the hours with psychodynamic formulations learned in previous treatments, or for therapists who regarded these formulations as anything but resistance to the current work. While she was often characterized as "gentle," we wondered—as we read her very tough comments—if this characterization simply meant that she was gentle when compared to the notoriously temperamental and abruptly caustic Harry Stack Sullivan. But perhaps her demeanor and mellifluous accent served to soften her sometimes hard words.

Fromm-Reichmann had a strength of personality which she seemed to assume everyone else possessed, or could possess. Thus she did not seem to worry about hurting a fellow colleague's feelings, nor was she condescendingly gentle with her patients. For both groups, she seemed to work under the principle that "the truth shall make you free." For example, in one conference, a staff member asked the therapist, in the discussion following his presentation of his work,

Staff member: Do you really feel you couldn't handle her if she jumped you?

Therapist: If, after a skirmish in which I felt I had to get the hell out, I say, I can run pretty fast.

FFR: What we hear is that you made contact with her and that she talks to you, but I have a hard time hearing what other directives you have in conducting this treatment, other than "Thank God, we talk to each other," not using the talking to each other for any *purpose* and it could be that

you haven't been active or positively aggressive there for the reason you just mentioned, that you are afraid.

(and in another conference:)

FFR: Well, you do not only do it inadvertently. I couldn't repeat the examples but while listening, before I knew to what conclusion you would come, I thought at quite a number of places, why do you take the attitude that it could be this or that instead of what is dynamically or genetically behind that?

Therapist: I thought of her, the same thing I said the first time I presented her, that first of all one has to build up a little bit more of what is called the ego or the self before she can make use of insight. It isn't that she doesn't make any use at all, but she doesn't have too much of the ego to assimilate it.

FFR: Then we come to the problem: can somebody use his ego strength by virtue of us telling him how, or by virtue of us helping him to do away with the dynamic and genetic reasons which hinder him? I don't have the feeling that this girl is so weak that she can't follow you if you do it analytically. Try to show her what hinders her from being herself rather than showing her: "This is the way that I, your supporting doctor, think it should be done."

Therapist: Do you have an example about what you are referring to?

FFR: For instance, at the point when she says she wants to go home for Thanksgiving and you say, for this or that reason, you don't think it is good. I would assume that the woman knows it isn't good. And I would ask why she wants to do something which she knows won't work out well. Examples of that kind, I think, happened several times. In a way, I would feel that you give her less credit for what she has, namely, not too bad an intellectual equipment and a not too crushed self, but you don't help her to develop it as long as you believe it has to be developed by supporting it.

Strangers coming to her office in her cottage frequently were said to have mistaken her for a housekeeper. They expected her fame to be accompanied by elegance. But she was four feet ten inches tall, overweight, no longer beautiful or stylish, and she dressed up neither herself nor her ideas and feelings. She

worked, spoke, and lived diligently, with what we came to experience as a *fierce* dedication. It seemed to me as I read these transcripts that when she spoke, the staff listened with something of the apprehension I would feel when my mother would check over my ironing or dusting, making me do it over if there were wrinkles around the buttons or dust on the chair rungs. Joseph Margolin, a frequent visitor at the Wednesday conferences, sensed that at the end of each presentation the staff would look toward her to get a sense of her approval or disapproval, and he felt they then often conformed their judgments to what they felt her facial expression conveyed. Margolin's observations suggest a conformity and deference. However, Harold Searles, who was very much a participant for years, when told of this account, adamantly said that he could not recall anything of that sort occurring.

Historical Chronology

The conferences prior to 1942 were generally inadequately recorded and contained frequent gaps and obvious errors in transcription, but they did convey the character of the hospital as a much more informal and problem-oriented place. Patients were mentioned by the small group of doctors within a few days of their arrival, but not in a detailed or structured way. The patients who were creating disturbances were the ones most discussed. Seven or eight doctors would debate whether a particular patient should be allowed an outing with the visiting family or should be transferred to a more disturbed unit or allowed to go with another patient on a shopping trip. A commonly discussed matter was that of alcoholic patients sneaking into town for liquor. A patient of Fromm-Reichmann stole a bottle of ready-made dry Martinis from her cottage and drank it on the unit. Fromm-Reichmann commented, "It was especially malicious because she knew that nobody else would have ready-made Martinis; *anybody* knows well how to mix them, so that bottle with that label clearly came from me. The hospital sees she got liquor from her therapist and drank it."

Sedatives were used surprisingly frequently, including sodium thiocyanate, called rhodonate, which, having shown initial

promise in diminishing psychotic agitation, was withdrawn from the market when it was demonstrated to cause neuronal damage.

A vignette from the early 1940s, in which the staff discusses a severely agitated man, illustrates these features:

FFR: What does Dr. Sullivan suggest?

Therapist: Insulin, but I haven't had enough experience and would not be willing to try.

FFR: But in principle, he thinks we should?

Dr. A: I would like to try sedatives at night and benzedrine in the morning.

Dr. B: You would not want him with a hangover.

Therapist: Not with a hangover but if more relaxed, it wouldn't be so bad.

Dr. C: Some people are actually physically uncomfortable with a hangover but others just dopey.

FFR: Could you change your hour with him, seeing him later in the day?

Therapist: Yes. I am not going to see him until tomorrow afternoon.

Dr. D: Why not small divided doses in the daytime, heavier doses at night, and then if this does not work, we can resort to more drastic doses.

FFR: That doesn't seem to me to be a good idea.

Therapist: He has a reluctance to be dopey. He is pretty well convinced it is a hallucination.

Dr. A: But he is not supposed to accept it as a hallucination?

Therapist: He says he can't believe it is a hallucination because the voice is so much smarter than he ever was.

Dr. B: I would knock him out at night and see what you can do with him in the morning.

FFR: Do you want to knock him out completely or give him enough to relax and then be able to talk to you as he comes out of it, or give him sodium amytol so slowly and in such small doses?

Therapist: I am opposed to that. He has asked for sedatives. What do you think of the idea in general?

Dr. C: It gets right back to what Dr. Fromm-Reichmann said. If given a larger than average dose at night so he would sleep soundly but when you saw him the next morning

maybe he would not be fully awake but still able to see you and then give him another small dose for the day and a larger dose for the night.

FFR: It seems you should give it but not deprive him of his doctor.

In addition, Fromm-Reichmann volunteered to administer sleep therapy. When electroconvulsive therapy seemed to some to be indicated, she wondered about referring patients to other places, and later spoke in adamant opposition to its use at the Lodge.

By 1944, the conference had become more focused, dealing with one patient per conference. Increasingly, Fromm-Reichmann's comments became more instructional, and the conferences became more analytically oriented. In the following vignette from a 1944 conference, Fromm-Reichmann challenged the therapist, as I believe she continually challenged herself.

FFR: Yes, but the way you go on now making her talk about irrelevant things just to keep her talking will *not* do something toward her cure. She gave you quite a number of openings and each time you missed them. If you had asked a question instead of meeting a statement, you would have pushed into the thing considerably. . . . [The patient] said, "If I ask somebody to give me a cigarette and it's not the right thing, I would be too lonely." And you say, "Well, you learn to do it, then you won't be so lonely." In the meantime she burns a hole in her dress in despair, because you give an answer to a statement the validity of which you have no way to understand. You have a chance to find out what she wants to tell you there. See what I mean? You will find out something which is quite understandable, trying to let her see that you go with her. But you respond without knowing what she has told you, and therefore the response is only an expression of your good will, and does that contribute to her understanding, because at that moment, you don't know yet what she is telling you. . . . Consequently there is only one person who can help us to understand what she means, and that is she. If she gets a statement which amounts to reassurance, it closes the discussion, but

we are trying to understand because the patient is schizophrenic and we are not schizophrenic enough to have it mean the same thing. . . . Perhaps she will tell us what her mother has done to her, and that is the thing that counts.

This quotation alluded to Fromm-Reichmann's ideas at that time concerning the schizophrenogenic mother.

Nor were fathers immune from bearing responsibility:

FFR: Would you visualize [the patient] . . . as somebody who has been told as a child what a wonderful father he has, told by everybody. And he knew better because in the relationship with him, he had no wonderful father. . . .

Therapist: Even in the referring doctor's original letter here, what he said was that he hoped we could take this fellow because this was such a splendid family.

FFR: This fellow has a terrible secret, "My adorable father is not adorable, namely, as my father" and that he can't tell because nobody will believe him.

In later years Fromm-Reichmann came to see the parent-patient relationship as less one-sided as revealed in a 1954 conference in which we see evidence of the evolution and mellowing of these ideas.

FFR: I think that . . . now that she is in the strong positive [transference mode]. . . , I think it is terribly discouraging [for her] when she hears you say that the relatives are a lost cause, and also I don't think it is true. Any patient who really recovers with insight automatically changes the entire manner and attitude of the relatives toward her. To her, if she hears you say that the relatives are a lost cause, that means she is one. Therefore, I think it is dangerous, and I think it is not so. It is our experience that whenever a patient gets well, it has the power to change the relatives. Now, if she breaks out of all the hostile interplay and resentment by virtue of her insight, the mother and father will change too. If she learns how to get along with the parents, the parents will get along with her. You are the intermediary for that.

From late 1949 through mid-1951, Fromm-Reichmann

rarely attended the conferences. The years after 1951 were richest in revealing her style of influence on the Lodge staff. Therapists very frequently acknowledged the helpfulness of her supervisory work with them when they reported in staff conferences. As the following example demonstrates, these therapists were not simply saying "thank you," they were eloquently summarizing essential features discovered in the supervisory process:

Therapist: I finally saw Frieda on May 26, and I had been trying to do it for a long time. She indicated that I talk too much, and I said, "Oh, no, Frieda, four or five minutes go on and I don't say a word!" She said, "But you use too long sentences, too involved sentences. You should simplify them." And she said that in response to this A-B-C-D-E, she would have immediately said, "F-G-H-I-J." I tried to convince her of the idea that some of my childhood experiences were causing the current anxiety between me and this threatening patient, and she said no, it is a matter of my competitive and critical feelings toward the previous therapist who had worked with this patient. I didn't go along with that and I still don't to some extent, but it is there for what it is worth. I did change. I stopped talking so much and I made a definite point to cut down on the length of my sentences, to make them simple. This was the latter part of May. I went in once and he said, "How are you?" I said, "Here to talk." He said, "You do the talking." Later there was laughter and exchanging of glances, whereas previously I had found it very difficult to look at him. I would usually keep my gaze averted and if we looked at one another, it would be him looking at me and then casting his eyes aside, and then me looking at him and then casting my eyes aside.

Over the years, the conference reports developed a shared focus and organization that very definitely reflected a group responsiveness to Fromm-Reichmann's directives. Much less time was spent reporting past history. In its place came an increasing openness regarding the details of therapeutic exchanges and the therapists' ideas and feelings about the relationships. Evidence of hostility in either the patient or doctor was valued as a potential clue to the underlying anxiety, the

ambivalent relationship with a parent, and then (quoting Fromm-Reichmann), the "continual question in the air, 'Where is that true in the relationship with me? [the therapist].'" Very frequently, Fromm-Reichmann would comment that the therapist saw the patient one way, but she had seen the patient in another, and then would give an example. She always added that the question was not which one of them was *correct*, but what could the patient teach them about these different aspects of himself.

Fromm-Reichmann seemed to be more explicit in her praise of therapists' work as well. For example, she said,

FFR: I could begin with saying that [the therapist] really hasn't done justice to the work that he has done with her. What I have heard in our private conversations was much more extensive regarding this very useful therapeutic exchange than he conveyed to us here. As a matter of fact, I think that he has gotten the woman from a state of being entirely in a defensive escape, trying to escape into sexual relations with him, not talking, and so on, to somebody who is now able to attach realistic labels to some things and who shows some insight about her sickness.

From 1955, when she spent the year in Stanford, California, at the Center for Advanced Study in the Behavioral Sciences, until her death in 1957, Fromm-Reichmann rarely attended conferences, perhaps due to her increasingly incapacitating hearing deficit. During those years the Lodge held some fascinating conferences and seminars on the initial impact of the psychotropic medications, but so far we have found no record of any comment made by her on this subject.

Although Fromm-Reichmann's conference comments were quite explicit, she was never verbose. Indeed, her contributions over the years reveal her to be the master of the one-liner, our favorite of which is, "We may be as wise as they come, but we don't like outpatients who have relapses."

Fromm-Reichmann's Presentations

As we read Fromm-Reichmann's presentations of her own work, we found that the legend of her godlike immunity to fear

is only slightly exaggerated. Her work with a thirty-year-old chronically paranoid, hallucinating, assaultive man, when she was in her sixties, attests to that.

FFR: Well, when he first came in, pretty soon without any challenge as far as I know, he looked around and seemed kind of surprised that I would see him in my office which, since I live in it, did not seem sufficiently officelike to him, and he said after we closed both doors, "But you know, I could knock you down in no time. You are an older person and I am a strong young man." I said, "Yes, I know." "Did you hear me? I could knock you down in no time? Do you want it?" I said, "No, I definitely don't want it, first because I don't want to be hurt, but second, and you may be surprised about that, I don't want it because I know you will feel so God-awful lousy if you do such a thing that I would like you to be spared from that." This seemed to impress him and he promised that he would never hurt me, a man wouldn't fight with a woman. This was half amorous and half in a despising way.

Later in the work, the patient was clearly attached to Fromm-Reichmann and had raged at her that she wouldn't be able to go on an announced vacation, because he would kill her rather than let her go away for four days. Since he previously had barged into her office in her home, when he did so again, Fromm-Reichmann latched the door. She described in her case presentation,

FFR: He shouted, "So you really think you need protection from me!" He kicked the screen door in with his heel. I closed the wooden door and told the girls to close the other wooden doors which he heard. He took the chair from the front porch and tried to get through the wooden door. In the meantime, we called for some attendants to help. As he saw them coming, he went down the porch and took the chair and battered it against the house, not against the windows.

Fromm-Reichmann and the patient continued to work together. After a phase in which he was regularly in cold

wet-sheet pack for the sessions, the man gradually became calmer and more social. As he came to trust Fromm-Reichmann enough to reveal the secret that he hallucinated—and then to work on analyzing the meaning of these hallucinations—he developed increasing insight into, and partial resolution of, his paranoid psychosis.

The next two clinical examples illustrate the very rapid and profound changes in therapeutic technique that occurred between 1945 and 1955, changes which are still evolving but not as easily evaluated when one is in the midst of them. In the mid-1940s, she presented her work with a woman who had been chronically psychotic and then profoundly apathetic; she had made a very impressive partial recovery during her two years of work with Fromm-Reichmann. At that point, the patient guided Fromm-Reichmann through a shared reading of Emily Dickinson's poetry, after which she was able to share past efforts of her own and then resume writing poetry. Fromm-Reichmann sent the patient's poetry, with the patient's permission, to Conrad Aiken, who said, "I think the girl has undoubted ability." He had carefully annotated her poetry as to quality and poetic rationality.

When it seemed to Fromm-Reichmann that the patient experienced all this as a straying too far from a doctor-patient relationship, she purposefully told the patient she had been keeping process notes on their work together and would review these with her whenever the patient felt ready. The patient declined, but the two of them did a careful and lucid outlining of the pivotal features of the patient's history and of their work together. Fromm-Reichmann summarized the lively staff discussion by saying,

I remember when, maybe one year and a half ago, Sullivan and I weren't much acquainted and he did not know much about my work, I told him about this patient and he felt called upon to say something like, "But your life should not depend on whether your patients get well or not." And I laughed and said, "Well, what do you think? I try what I can and if she doesn't get well, she doesn't get well." And he said with a great sigh of relief, "Oh, then it is all right what you are doing."

Ten years later, in the closing remarks concerning a recovered schizophrenic, Fromm-Reichmann had been asked how she coped with a patient who seemed so awesome in her potential. She said,

FFR: As I told some of you when she first came, this girl reminded me of myself as a young child. She was overgrown, I was always too short. She was too fat, I was too fat. And as a little girl, I used to wear my hair the way she did. I think somehow that helped me to develop a very warm countertransference. Then too, I had a mother who was very proud if her daughters would develop as best they could all the talents which mother didn't have, but she didn't do it well. She got competitive. So, as long as I can think, I have done better along those lines. About ten years ago, I treated a young boy who knew the whole American and English literature and I caught myself being terrifically inhibited in working with him because at times he looked down on me. I didn't know what books he was referring to. . . . I discussed that with Dr. Sullivan and I think getting this kind of thing very clearly into focus with that boy helped me with this girl. . . . Now here is the first one in my 40 years of doing therapy who I think was not obsessive but schizophrenic and I think it is wise to work more intensely on *how* we know, who is *not* schizophrenic now. That means so much to me to have a brand-new professional experience at my present stage of life.

[In another conference on this same patient, she said,] It is an intense satisfaction to help that girl grow up to be better endowed than I am. Then I think I have done well in the way I would have liked to teach my mother to do, in fact, I have tried to, in her way of handling my younger sisters. Then the problem would come now after all, be it competitive? Sure, that girl is incredibly well endowed. If you ask me, I am pleased about every new accomplishment that I see in her and I believe it is true maybe for both reasons which I give. It is a little like a noncompetitive mother figure. And also it is very exciting to me.

It was interesting that with this patient she very scrupulously avoided any involvement in nonanalytic reading of the patient's poetry and acknowledged the change in her own technique,

contrasting it herself with the case I mentioned previously. Her style of work changed over the two decades here, and, as with Freud, she demonstrated an extraordinary ability to remain flexible and not locked into a loyalty to a formerly cherished approach. Over the years she gradually involved herself less in the events of her patients' lives, and was less actively interpretive in the sessions. The analytic directives had become increasingly internalized, and her supervisory comments in the conferences indicated that she had succeeded in conveying this approach to the staff as well.

Areas of special interest

Fromm-Reichmann was a researcher and she continually suggested areas for further study, noting, for instance, our lack of data on who should work with whom and our inability to predict outcome. She observed:

FFR: I can only repeat time and again as we discuss these things, that . . . many times, the patients we think have the very bad prognosis make it sometimes, and those about whom we think it will go quickly don't make it. That is, we do not yet know, first, what therapy can do, and we do not yet know what all the other therapeutic elements are doing which work in the hospital. Of course, gradually, we have to learn to have some prognostic ideas.

Fromm-Reichmann thought this issue could be approached by studying therapists' discouragements with particular patients. She urged the therapist, when the work began to get into trouble, immediately to begin making detailed process notes and to obtain supervision, whose helpfulness she repeatedly emphasized. In one conference, she stated,

FFR: One thing that came very clearly out in our work together is the significance of supervision—not because of what the supervisor may have to offer, but for the very fact that the privacy of two is changed into a relationship of three. There is the danger we have in entire privacy with a psychotic patient even more than with a neurotic; this is

broken through because we put in front whatever has gone on.

She repeatedly observed that when a therapist sought supervision on a case, his or her anxiety diminished as understanding increased. This was *then* followed by diminution of anxiety and hostility in the patient.

Fromm-Reichmann embarked on her own research project in group therapy with caution, meeting with six female patients who had not responded to individual therapy. Two talked; the others were mute, initially "expressing themselves, if things went well, exclusively with gestures, [otherwise] with urinating on the floor or laughing to themselves." Morris Schwartz, author, with Al Stanton, of *The Mental Hospital* (1954), was the group's observer and kept process notes. All six patients showed evidence of improvement, and there were many gratifying examples of group relatedness.

In 1950, Fromm-Reichmann's pivotal contributions to the staff discussions resulted in the formation of the small groups, an idea which had originally been introduced by Robert Cohen. These groups consisted of seven doctors who met twice weekly, with no set agenda, to discuss whatever clinical matter seemed most urgent or interesting, the groups keeping the same membership for about four years. This system still continues at the Lodge and is a cherished feature of the work week. Fromm-Reichmann had also been among those instrumental in the organization, in 1948, of study groups which focused on particular topics. One of these groups, headed by Robert Cohen, reported in 1949 on their study of countertransference. In the discussion that followed, Fromm-Reichmann commented:

FFR: Freud originally took as countertransference the reaction of the therapist to the patient which was not rationally called for by what the patient said or did, in or outside of his "transference reaction" with the analyst. Then he called countertransference *repetitional* reactions with the patient of the doctor . . . [of his] difficulties with his parental figures. . . . What you add here is what I think what Freud meant too, but it wasn't mentioned in so many words, that the *security operation* (Sullivan, 1954, p. 102) following

from these irrational "countertransference" reactions should be included in the concept. When we call it countertransference, it means it has its irrational factors stemming from other experiences of the doctor in early life or later. . . . leading up to *parataxic distortions* (Sullivan, 1940, p. 92).

There are some interesting data about that, incidentally. If it's true that each symptom is an expression of an innerness of which the patient wants to get rid, but also the symptom is a means of warding off more serious things, namely, anxiety, then by virtue of the therapeutic process, we are simultaneously the friend and the enemy of the patient. We are the friend of that part in the patient which wants to get rid of [that] innerness and we are the enemy of that part which needs symptoms to defend itself. I believe that in our great effort to see the single experience in terms of transference and countertransference reactions, we are a little in danger to forget that it is due to the dynamic bipolarity of symptomatology, an equally inevitable bipolarity in the reaction of the patient to the doctor and in the reaction of the doctor to the patient.

She was constantly alert to evidence of *unconscious* anxiety in the therapist, as is illustrated in the following vignette in which she deals firmly with the therapist, and conveys a sense of how she might have been similarly firm with the patient:

FFR: I feel there is something in her making you uncomfortable because . . . you didn't mention the word "anxiety." That is, you must have been somehow preoccupied and therefore at least not alert to conveying to us that behind all of this is a terrific anxiety. I would be very interested to know what other females were in her childhood. I have the feeling that she not so much wants to be a man and identify with father as she would like to be a female if she would know how, but she doesn't know how, has never learned how, and would therefore be afraid of it. I have a feeling that when she expresses all of her dependent needs on you, one might say, "What makes her so afraid of this dependency and why can't she fully express it, and why does she need it? Where is her anxiety there?" And where is her anxiety, if this woman with her very good intellectual equip-

ment, can't listen? Is it also because she is being preoccupied with being threatened to death about that which you may tell her?

So, I think there are the two problems: the terrific uncertainty first about what is male and female because father fulfilled the motherly needs on the one hand, and a longing for being female which she doesn't know how. I hear her all the time driven by anxiety and I would think if one would take that fully into account, the difficulty Mary was talking about would also not be quite so terrific.

If you know that you are dealing with somebody who, as Margaret [Rioch, psychologist, who had reported on psychological testing of the patient] told us is pretty near the border of panic, I believe I would forget my own anxiety and discomfort, because I would get thoroughly preoccupied with "How can I relieve the anxiety of the other?" Therefore, from there I find it easier to deal with all the defenses you have told us about. For instance, "I would like to be friendly the way Father was, but I can't because I am not a man. I would like to be a female, but so help us, I would not like to be incapable as Mother was. I would like to listen to you, but I can't because you are telling me something which makes me more frightened, or that I am so preoccupied with warding off panic that I can't listen to you."

I would like to offer one more suggestion. Could it be that a patient who asks for so much, for such a tremendous amount of what she should get and what she has to get, what she didn't get, is really talking about her great distress about her sense of inability to ever give? I think she is. I think this woman is alert to knowing that here she runs around and is not ever to give anything to anybody. I think it is part of her complaint. . . . Would you say that we can say something like, "No matter what you didn't get as a baby, it cannot be made up at the present time, and that we can only get it if we give. Baby time is the only time that we get without giving, and unfortunately it is over and it can't be made up."

The following vignette illustrates that Fromm-Reichmann's supervisory commentary was not limited to the therapist then presenting his or her work.

Staff doctor: I was wondering about Frieda's remark which I've heard many times that a schizophrenic is confused not about his sex, but rather, confused as to how to play it, what position to take; because I never saw one that was confused about his sex.

FFR: I can't remember any schizophrenic where I couldn't see that.

Dr: I was wondering how they express it. How do you know that they're confused about their sex, or whether it is confusion about the role to play in various situations.

FFR: It is expressed very differently, of course, depending on the patient and the type of exchange you have with them and how articulate or not articulate he is. With many of them it is expressed, "Am I lovable or am I not lovable? And if I were a girl or a boy, would I be more acceptable?" And then in terms of the childhood history. That is one thing, and of course, we need to find out what is behind that terrible concern about being acceptable or not, or being able to perform or not. Problems of ability to accomplish or perform have sexual elements in it.

Dr: I took your statement to mean though that they didn't know what sex they were. Now, what you said then was the same thing I did.

FFR: Well, I think you could say that you find it in all degrees, not knowing, being very doubtful as to whether or not they are acceptable, having the fantasy then if they are doubtful, "Maybe I could try to be the other way around," and then being mixed up about the difference between fantasy and reality, which gets lost.

She focused on the patient's anxiety when listening to *administrative* decision-making as well as in listening to therapists' work. For example,

FFR: Does the patient, when he gets encouragement and permission to do something like going to the library, go into a panic because he can't stand the library, or is it sometimes because he gets terribly frightened because [he feels] we don't know how sick he is? I've had the feeling with [a patient of mine], when she made her first attempt to go on the outside, that she would become severely sick because it meant [to her that] I might have lost sight of how

sick she was, and that her panic states were not the response to what she did, but the response to the actual or alleged error in judgment on the part of her doctor.

Fromm-Reichmann demonstrated her skill in working with dreams in another conference, stressing the danger that the analyst can see himself or herself in these dreams to too great an extent. The therapist had lost sight of the dreams as conveying unresolved difficulties from the past, or with others in the patient's current life. Fromm-Reichmann stressed that this danger related closely to guilt feeling in the therapist, which put the work in jeopardy, as the therapist would then feel a need to atone for previous errors.

There were examples of her impressively focusing on the central transference dynamic, which had been overlooked by the therapist and administrator. In one such instance, the therapist had endured a prolonged, silent, withholding regression of an obsessional schizophrenic who had, early in their work, seemed to show great promise. He had seen the patient's facial expression as continually hostile, while another therapist had seen it as grief-stricken. Fromm-Reichmann joined in the discussion with the question:

FFR: Has he brothers?

Therapist: He has one brother. The patient has two older sisters, and had a younger brother who died of peritonitis when he was nine and the patient thirteen. This brother had been by far the most outgoing, spontaneous, gifted and attractive of the children. The patient had told me he felt very much glossed over by the family.

FFR: Do you think that much that has gone on with you may be, especially where there is anger or jealousy, is a transfer from that brother who it seems first was a menace because he did away with his being the only son after four years, then because he was more alive, and then because he became glorified as a dead brother? I would think it might, all the more because I think there is one funny factor regarding your relationship. He faintly resembles you, and I would wonder what that means in his relationship with you. He could very well be your brother.

This came through as a stunning insight elucidating the therapeutic impasse, and was done in a way that would free the therapist to make maximal use of his then potentially liberated empathy.

While we have emphasized Fromm-Reichmann's remarks concerning the treatment of patients suffering from schizophrenia, we want to add that she spoke often about manic-depressive psychosis. She organized a long-term study and research group. It is especially important to keep its findings in mind in an era when we too readily imagine that lithium has somehow eradicated the illness.

FFR: Well, the manic-depressive, when you ask him about incidents in his personal life, will either evade it or will say that he doesn't know anything about it, whereas the schizophrenic *will*, if he can communicate, even though very mute and very symbolic about it. He will give you information about it because he is accustomed to thinking about it and has grown up in an environment toward which he is very hostile or ambivalent or which was very hostile or ambivalent [toward him], but which was very concerned about the child and themselves. Whereas with the manic-depressives, they are so concerned that everybody lives up to the Joneses and that the environment accepts them, they have much less real acquaintance with, and therefore very little ability to communicate about, their own problems. . . . I think that it is quite interesting that we have the feeling that we do not have enough information from and about the family. It's a feeling that we will always have about the manic-depressive because the information is so superficial and stereotyped that even if we talked with all of them, we still have the feeling that we have so little information about the background.

Vignette Categories

The twenty categories into which we organized Fromm-Reichmann's remarks included statements regarding the evolution of a philosophy of treatment; specific hospital techniques and research projects; remarks regarding signs, symptoms, and diagnoses; therapists' styles, aspects of which have already been

covered. Finally, what became the fullest categories were those under the headings of Fromm-Reichmann's style of supervision in conferences. A particular quotation would often be indexed in two or more categories.

We listed fourteen rather loose and somewhat overlapping types of supervisory comments, which could be consolidated to the following, listed in decreasing order of frequency. By far the most frequent were Fromm-Reichmann's suggestions, which were usually very practical and based on her personal knowledge of the patient. She also frequently theorized and interpreted, or clarified areas of confusion in a presentation. On many occasions, she taught by example, sometimes drawing on her own experiences either with the particular patient being presented or with one of her own patients, and sometimes drawing on the work of her colleagues, especially Harry Stack Sullivan. Less frequently, Fromm-Reichmann played detective, asking increasingly specific questions of the presenting therapist. In other types of interactions, she sometimes linked remarks of the therapist with another staff member's contribution; she was sometimes confrontative; she was sometimes simply supportive. The smallest category of supervisory comments was "humorous."

Conclusion

Fromm-Reichmann was profoundly dedicated to a belief in the ability of analytic insight to transform a person's life through the resolution of anxiety. She assumed a similar fortitude in her colleagues and dignified them through that assumption, interrogating them while implicitly believing that they too wanted their own defensive patterns to be revealed and then resolved. Fromm-Reichmann felt strongly that schizophrenic patients respond well to, and even require, clear administrative statements. While she did not say so, it seemed to us that she felt that therapists and administrators needed such clearly stated directives as well, and she *treated* them accordingly. She was absolutely even-handed in her statements to the male or female staff members, but seemed to bristle at defensiveness and to attack vehemently masochism and self-blaming.

She aggressively and positively searched for the unconsciously hidden truth, sometimes patiently waiting, at other times actively seeking. While remembered for her tact and politeness, she still maintained that false gentleness and reassurance are really despicable and destructive. Her alertness to the vicissitudes of manifestations of anxiety informed perhaps every comment she made, and formed the core of her helpfulness, a helpfulness that has been so powerful that we are still expressing our gratitude over thirty years after her death. Reading these charts, we found Fromm-Reichmann's comments impressing upon us yet again that while we may prescribe medications, we, as therapists, administrators, or other hospital personnel, are psychoactive agents. Whether things are going wrong, or, more challengingly, when they seem to be going along well enough, we must always be working, whether in a listening or an interpreting mode, with a psychoanalytic *directedness*, defining the patient's patterns of defenses, formulating what they seem to be defending against, and being continually alert to that which is being stirred in *us*.

The general psychodynamic conception that anxiety plays a central role in all mental illnesses and that mental symptoms in general may be understood simultaneously as an expression of and as a defense against anxiety and its underlying conflicts holds, regardless of the severity of the picture of illness and regardless of its more or less dramatic character. Hence we make the exploration of the dynamic roots of the schizophrenic's anxieties our potential goal through all phases of illness [Fromm-Reichmann, 1959, p. 195].

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