Modern Psychoanalysis of the Schizophrenic Patient

Theory of the Technique

2004 Second Edition

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YBK Publishers
New York

CONTENTS

In general, the *higher the developmental level* at which the patient enters treatment, the *broader the range of therapeutic communication* that he can tolerate and the less urgent it is for the analyst to operate strictly within that range. Silence does not mobilize much explosive force in a patient whose problems are oedipal in nature because the capacity for verbalizing emotional energy is well developed. The patient can discharge those high states of central excitation associated with sensory deprivation rather readily in speech. There is relatively little danger that the patient will release efferent impulses into undesirable forms of motor activity. A wider range of communication is therapeutic as well as tolerable. Because of a relatively long course of wholesome development, varying degrees of verbal contact *create situations* which favor the resolution of resistance in the case.

The immediate release of efferent impulses into motor activity—acting out—is characteristic of the most primitive mode of functioning. Patients entering treatment for preoedipal problems have a limited capacity to engage in precise verbal release; they tend to discharge their impulses into indiscriminate forms of motor activity rather than speech. This tendency and the attendant dangers create anxiety, and inhibitory tensions are mobilized. In order not to stimulate the operation of the more primitive action patterns, one therefore refrains from exposing these patients to extreme degrees of sensory input or sensory deprivation in terms of verbal contact. To control the mobilization of aggressive impulses by the patient and secure their release in language, the analyst adheres rather strictly to a narrow range of communication. This militates against the threat of iatrogenic regression.

Schizophrenic patients often appear to tolerate the absence of verbal contact for prolonged periods far better than less disturbed persons. They do not verbalize their aggressive reactions to such deprivation as readily as, for example, the psychoneurotic patient. Some of them go on talking for many sessions without soliciting any communication from the analyst.

However, the misdirecting influence of frustration-aggression is implicit in such behavior. Not being in command of their aggressive reactions, these patients can only conceal them—the schizophrenic reaction. Their tendency to store up aggressive impulses reflects an extreme need to inhibit their discharge.

To prevent a potentially explosive situation from developing, and to deal therapeutically with these defensive reactions, the analyst restricts his gratification of the patient—in terms, that is, of verbal contact. Rather than the moderate dosages at varying intervals to which the psychoneurotic patient responds, the psychologically healthful diet for the schizophrenic patient early in treatment is usually minimal dosages of communication at relatively long intervals. During the first twenty minutes of the session, in particular, interventions are, in principle, as few and as widely spaced as the situation permits. Toward the end of the session, more communication from the therapist may be needed to facilitate the patient's leaving the office.

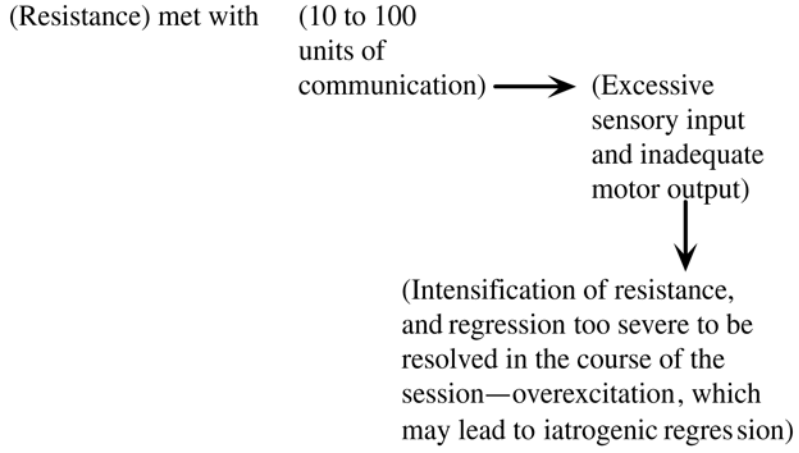
What is the actual difference between "moderate" and "minimum" dosages of communication? Since firm measurements are impossible, the term "units of communication" is introduced to suggest the difference.

One unit of communication, viewed as a verbal feeding, would be the equivalent, say, of a mouthful of milk. It is the briefest of interventions, such as a single question or very short statement. These communications may be ego-syntonic or ego-dystonic. The units stipulated below represent an estimate, on a long-range basis, of the amount of time the analyst spends in talking to the patient.

Quantified roughly, the analyst's communications to a patient being treated for oedipal problems range from 10 to 100 units; the range indicated to deal with the characteristic defenses of the schizophrenic patient is from 2 to 5 units. The difference between these two types of verbal feeding is comparable to that between the normal dietary needs of the adult and those of a child who has been conditioned to underfeeding.

In general, in the formative stage of the relationship, verbal contact with a schizophrenic patient is rarely in order. It is desirable that the analyst remain under the specified five units until the narcissistic transference has been resolved. Between the regular brief feedings at relatively long intervals, two additional units are occasionally provided when demanded. Whatever resistance the patient develops to a transference object experienced as being like oneself, or even a part of oneself, yields temporarily to a few appropriate words, preferably spoken when a communication is solicited. The intensity of the resistance can be more easily influenced when the analyst limits and times communications in the manner suggested above.

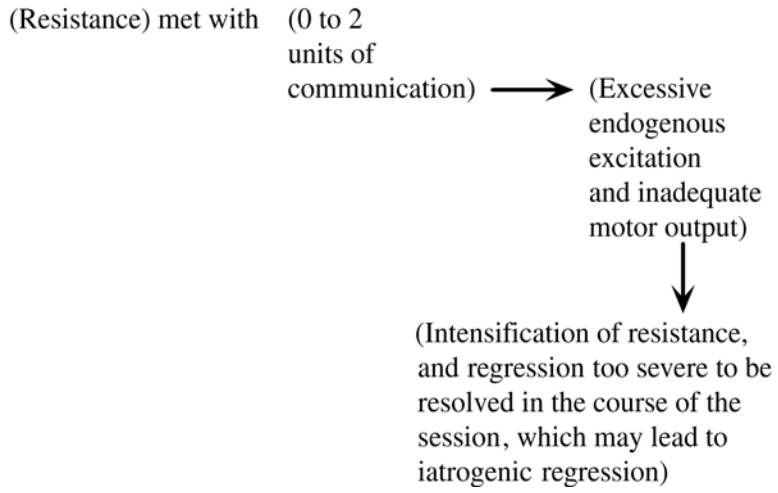
The development of the case when one tries to deal with resistance through larger dosages of communication at shorter intervals—the customary procedure in other cases—is indicated in the following diagram:



The situation delineated above is especially undesirable in the outpatient treatment of schizophrenia; indeed, it was probably a contributing factor in

many failures that have been reported in such treatment. The danger of precipitating iatrogenic regression in persons being treated on an ambulatory basis usually mounts when they are exposed to "overfeeding." Too much communication creates more excitation, primarily exogenous, than the patient can discharge appropriately. That situation is averted by respecting the patient's need to develop and work through the narcissistic transference in a state of *mild* frustration-tension controlled by minimal gratification. That, indeed, is my prescription for the psychotherapy of the schizophrenic patient.

Analytic therapists who equate the classical approach with passivity and have been educated to the idea that this is unsuitable for the schizophrenic patient are more apt to exceed the range of two to five units of communication than to operate below it. Nevertheless, it is possible to veer toward the other extreme; failures that appear to be associated with "verbal starvation," one of the factors contributing to emotional drought, are occasionally encountered:



Too little communication is as deleterious as too much and for the same reason: the relative inadequacy of motor output.

Resistance originating in the narcissistic defense can be resolved without undue difficulty when the analyst consistently limits himself to small dosages of communication at long intervals. After the narcissistic transference evolves and the patient begins to relate more characteristically to the analyst as a separate object, he is more capable of verbalizing feelings. During the transitional stage, the communication dosages are gradually increased and the intervals between them are shortened. The patient develops an increased tolerance for more communication, and finds it pleasurable.

The development of object transference usually signifies that the reorganization and reintegration of the patient's energy system have reached the point where he can respond appropriately to larger verbal feedings. When exposure to from 10 to 100 units of communication reactivates the old resistance pat-

SUBJECT INDEX