

The Partnership of Psychoanalysis and Psychiatry in the Treatment of Psychosis and Borderline States: Its Evolution in North America

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Abstract: The history of psychiatry is about two hundred years old and that of psychoanalysis more than a hundred, with an important anniversary of the latter in 2011. Freud renewed and humanized psychiatry by enriching its static descriptive method with the new dynamic and interpretive discoveries of psychoanalysis. Freud's innovations, while developed in Europe, were integrated into psychiatry briefly by the Swiss School but mainly in the United States. After many years of fruitful collaboration psychiatry and psychoanalysis seemed to part company in the U.S. in the last few decades. However, the tradition of combining psychiatric care with dynamic principles is still considered valid in the treatment of psychoses and severe personality disorders.

As we are celebrating two centenaries, the founding of the International Psychoanalytic Association in 1910 and of the American Psychoanalytic Association in 1911, it is well to revisit the contribution psychoanalysis has made to psychiatry, especially in the treatment of psychosis, and specifically in America as compared to Europe. The chosen psychotic paradigm is schizophrenia and severe personality disorders even though psychoanalysis has also dealt with bipolar disorder. The chosen focus is treatment, for at the end of the day both psychiatrists and psychoanalysts are judged by the difference their treatments make in the lives of the people they serve. Since the rise of psychiatry about two hundred years ago and of psychoanalysis about one hundred, both

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have been concerned with defining their identity as pursuing a profession, a science, and a therapy.

In the course of that history two major conceptions of the nature and treatment of psychosocial disorders called neuroses and psychoses emerged, the *somatic* or biological and the *dynamic*, or psychological and social, also called psychodynamic. In the first half of the 19th century the leading representatives of the dynamic conception were Philippe Pinel and Jean-Etienne Esquirol in France and Johann Christian Reil and Johann Christian August Heinroth in Germany, the latter collectively called the *Psychiker*, distinct from the *Somatiker*, the psychological psychiatrists and the biological psychiatrists. In the second half of the 19th century, the German psychiatrist Wilhelm Griesinger still combined both approaches, but his dictum that "mental diseases are brain diseases" paved the way for the ultimate victory of the *Somatiker* over the *Psychiker* and the rise of "an overall system of organic and mechanistic psychiatry" (Ellenberger, 1970, p. 284), coercive and often cruel, using somatic treatment such as drugs, bed rest and isolation, hydrotherapy and electrotherapy, with little or no recourse to psychotherapy. The somatic, as an organ and body oriented approach, had its roots in the millennia-long tradition of medicine which examined the sick body and treated it with drugs and surgery. Even as Emil Kraepelin (1856-1926) was seen by Ellenberger as caring and utilizing multiple approaches to psychopathology, his system of psychiatry was predominantly descriptive and static. The tradition of the *Psychiker* made a comeback in the late 1880s with two Swiss psychiatrists, the founders of the Zurich school of psychiatry. The first was Aguste Forel (1848-1931), the teacher of the Swiss-born Adolf Meyer and an early champion of psychoanalysis in the United States. The second was Eugen Bleuler (1857-1939), successor of Forel as director of the famed Burghölzli asylum, the first in 1896 to endorse Sigmund Freud's (1856-1939) epochal *Studies on Hysteria* (Bleuler, 1896), who conducted experimental studies of thought association and promoted psychoanalytically based psychotherapy in the treatment of psychotic patients. By 1900 the Zurich school gained an important member: Carl Gustav Jung (1875-1961). Bleuler and Jung were the first, if not the only ones, to give early scientific recognition to psychoanalysis in German-speaking countries.

Even as this evolution is described in the other influential histories of psychoanalysis and dynamic psychiatry (Hale, 1981, 1995; Makari, 2008), the details relevant to our topic are presented more compellingly in the personal history of the founder of American psychoanalysis, Abraham Arden Brill (1874-1948; Oberndorf, 1953). His two last books (Brill, 1944, 1947) were the "fruit of more than four decades of close application to psychiatry and thirty-seven years of active participation in

the psychoanalytic movement" (Brill 1944, p. 9). In his numerous publications he made an essential contribution to psychiatry and psychotherapy in America. He founded the New York Psychoanalytic Society in 1911 and was co-founder of the present American Psychoanalytic Association in 1932, reconstituted in 1946 (Oberndorf, 1953), the latter destined to play a crucial role in the world-wide spread of psychoanalysis after WWII.

Brill was born in the Polish town of Kańczuga (formerly Austro-Hungarian Galicia) which he left "at the age of 14 and came, alone and without resources, to the United States and New York City to seek his fortune. By the time he was 29 he graduated from the Columbia University College of Physicians and Surgeons and then trained in psychiatry and neurology" (Richards & Mosher, 2006, p. 386). Brill was unique in having had extensive experience as an institutional psychiatrist and who later, as practicing psychiatrist and psychotherapist, achieved many therapeutic successes.

Initially it was Adolf Meyer who had a transforming influence on the eager neophyte in psychiatry. Brill had borne witness to the bleakness and hopelessness of custodial psychiatry as reflected in the "notes of the pre-Meyerian period: 'John Doe, 26, single, laborer . . . excitable, delusional, shouting and screaming.' A year or so later, the second note read: 'The patient is stupid, dull, and demented.' Some years later . . . by another physician: 'Patient continues as above.' Then there was the final note: 'Patient died suddenly' " (pp. 17-18). Adolf Meyer, Brill's first teacher of psychiatry in 1903,

taught [him] to describe the patient's attitude and manner, his anthropological make-up; we examined all the phases of his orientation, memory, judgment, insight, etc. Last but not least, the psychiatric examination was always preceded by a thorough physical and neurological examination. The average case history ran from twelve to sixteen typewritten pages . . . they were quite complete . . . laying stress on the normal and abnormal psychic development; The treatment was purely symptomatic. (Brill, 1947, pp. 4, 6)

Meyer's approach, focusing on the biological, psychological, and social factors of the case later called psychobiology, was an essential contribution. Subsequently fused with psychoanalysis it was the guiding principle in the two first *DSMs* of 1952 and 1968.

The second important phase of Brill's education as a psychiatrist took place in 1907-1908 under the guidance of Bleuler and Jung, when he was 33 years old. Brill first heard about Freud serendipitously in 1905 in a chance meeting with an Austrian officer. Similarly, the prominent

New York neurologist Dr. Frederick Peterson, who met Brill in the summer of 1907 in Paris at the famed Salpêtrière (where many had gone before, including Freud himself), “suggested . . . that I go to the psychiatric clinic headed by Bleuler and Jung” (Brill, 1944, p. 12), which Brill did later that year. Prior to that, during his “New York State Hospital career [Brill] had been an assiduous student of psychiatry . . . [and] almost became Kraepelin’s translator” (p. 14). However, after his stint at the Burghölzli, he “devoted [himself] altogether to the study of psychoanalytic psychiatry . . . as psychoanalysis is one of the most important contributions to the psychiatric armamentarium” (p. 14).

The atmosphere at the Burghölzli differed vastly from what Brill first encountered in an American psychiatric hospital and from the way psychiatry was practiced in most Austrian and German asylums of that period: a central concern here was psychological treatment. The doctors lived on the premises and mingled with the patients; Bleuler’s own sister was a chronic patient there. Founded by Griesinger in 1870, its second director became Forel, who, like Freud after him, traveled to Nancy in 1887 to study hypnotic suggestion from Hippolyte Bernheim, made it a staple of treatment at the Burghölzli, and published a book on hypnotism in 1889, reviewed by Freud (1889). Brill (1944) was influenced “by Forel’s work on hypnotism” (p. 13). In 1905, the same year Freud published his *Three Essays on the Theory of Sexuality*, Forel would publish his famous book, *The Sexual Question*. When Bleuler took over from him in 1898, he had already experimented on thought associations and published a favorable review of *The Studies on Hysteria* (Bleuler, 1896). By 1900, when Jung joined Bleuler as his chief assistant, Freud’s *Traumdeutung* was added as the standard work on dream interpretation, adding the Freudian method to the therapeutic armamentarium. By 1904-1905 Sabina Spielrein was both successfully treated there by Jung with Freud’s method and participated as an assistant in Jung’s association experiments, published in Jung’s *Diagnostic Association Studies*, which he sent Freud. Freud’s letter of thanks started a most remarkable correspondence and relationship in the history of psychoanalysis. In 1906 Bleuler published on Freudian mechanisms in the genesis of psychosis. By 1908 Bleuler and Jung joined the psychoanalytic movement. Brill was brimming with enthusiasm about his experiences at the Burghölzli:

It was inspiring to be in a group of active and enthusiastic workers who were all toiling to master the Freudian principles and apply them to the study of patients. Psychoanalysis seemed to pervade everything there. When one made a mistake in talking, he was immediately asked to explain it, and the frankness that was displayed on such occasions was truly amaz-

ing. Here was a group of experienced psychiatrists, Bleuler, Jung, Riklin, Abraham and Hans Meier, all working overtime in order to find something new. At the time of my visit, they all seemed convinced that the Freudian mechanisms existed in every patient. Bleuler was not yet convinced of Freud's sexual concepts. (Brill, 1944, p. 30)

Association studies translated into therapeutic work. The concept of "emotionally-accentuated ideas, or complexes" (p. 95), that arose from the associations experiments by Bleuler and Jung, Freud's ideas about compromise formation and "the mechanism of identification . . . patients impersonate all the parts of a drama" (p. 118), revealed by Freud's method of free association, all this "inaugurated a new epoch in the psychiatry—the method of interpretative psychiatry" (Brill, 1944, p. 32), which he also called psychogenetic, that is, psychogenic. Applying this method Brill became "captivated by the case histories because the patient no longer represented something entirely foreign to me, something insane, as I had hitherto regarded him when I merely described his strange behavior. Now even his most peculiar expressions as I traced them back to his former normal life struck familiar chords in me" (p. 33). Such attunement based on understanding and intuition also implied that this was an interpersonal communication, although "interpersonal" had to wait for Harry Stack Sullivan to put it on the map. Describing mutual dream analyses practiced by the doctors at the Burghölzli amongst themselves, Brill wrote:

If one gives free association to anyone who analyzes his dream he opens up, as it were, his whole psyche—that is, if he really withholds nothing that flashes through his mind. Most of us were perfectly frank . . . such mutual help in dream analysis turned out to be most successful if carried out by those who were in sympathy with each other . . . as a result of these experiences the Zurich school was the first to advocate what is now officially designated as training analysis. (p. 42)

It is easy to see how such mutuality applies to the analysis of patients. In addition to Brill, a galaxy of future psychoanalysts worked or was trained there: Abraham, Binswanger, Eitingon, Ferenczi, Jones, and last but not least, Sabina Spielrein, who in 1911, under Bleuler's and Jung's guidance, would publish her medical dissertation on the meaning of the "psychological content of a case of schizophrenia," a woman she treated at the Burghölzli. The meaning of psychotic behavior, Freud's basic tenet, was a primary interest there.

In the third period Brill devoted his professional life to psychoanalytic administration, education, founding the New York Psychoanalytic

Institute in 1931, and publishing. In 1909 Brill translated Jung's 1907 *Psychology of Dementia Praecox*, written under Freud's influence and including a discussion of Schreber's symptoms: "the first translation that [he] made in the field of psychoanalysis, and it was the first English book on psychoanalysis. In this work Jung showed that the Freudian mechanisms are all found in dementia praecox just as they are found in hysteria" (Brill, 1947, p. 15). Also in 1909 Brill became the authorized first translator of Freud with the publication of *Selected Papers on Hysteria and Other Psychoneuroses*, published by the Journal of Nervous and Mental Disease Company. His volume *The Basic Writings of Sigmund Freud* became, after the Joan Riviere 5 volume set of 1924, the main source of Freud's works in the U.S. before the *Standard Edition*. Brill published books about psychoanalysis in 1912 and 1921 that went reprinted and re-edited repeatedly, expressing a life-long admiration and loyalty to Freud while capable of voicing disagreements with Freud or even poking amiable fun at him. When Brill submitted his interpretation of a patient's verbal hallucination as a "condensation of his love affair" to Freud and Jung, Brill quipped about "having received the approbation of 'Allah and his Prophet,' as we were then in the habit of referring to Freud and Jung, as well as to the Vienna Psychoanalytic Society" (1944, p. 91). However, over the years the most revealing and relevant to our topic were the many case histories of psychotic patients (with one or two exceptions) that Brill treated either as inpatients or outpatients, not only cited in the abovementioned books but in numerous clinical papers. In these case histories Brill revealed himself as a humanistic, compassionate, intuitive and empathic therapist—in short, a man of great tact and clinical wisdom.

It was surprisingly unknown to Brill himself (1944, pp. 49-50), that Freud was not only trained as a neuroscientist and neurologist but also had a psychiatric training, had examined psychotic patients and wrote up their case histories before he became a practicing psychotherapist and psychoanalyst. Prior to journeying to Charcot, Freud did a five month stint as an assistant on the psychiatric service of psychiatrist, neuroanatomist, and sometime psychologist Theodor Meynert (1833-1898; Hirschmüller, 1991). After discovering the method for decoding the manifest "meaninglessness" of hysteria (1895, p. 93) Freud went on to apply it to explaining the meaning of madness (Breuer & Freud, 1894, 1896), the content and intent of psychotic hallucinations, delusions, and paranoid projections. Such decoding was at the same time a method of treating them: "I had the opportunity of undertaking the psycho-analysis for therapeutic purposes" (Freud, 1896, p. 175); and for some time with a good result: "her disgust at eating . . . found an explanation . . . the hallucinatory sensations and images . . . [which]

have not returned" (p. 180). Ultimately the patient became ill again and ended her life in an asylum (p. 180, footnote 2 and addendum of 1922). Brill (1944) commented as follows: "In this analysis Freud endeavored to show that a psychosis, too, can be explained by psychoanalysis; that paranoiac mechanisms resemble those of hysteria and compulsion neurosis . . . that the symptoms of paranoia are determined according to the transformation mechanisms of the psychoneuroses" (p. 91). This assessment was fully endorsed by Bleuler's paper on Freudian mechanisms in psychosis (1906), from which Brill quoted as follows:

It is impossible to know the meaning of delusions without considering the Freudian discoveries. The content of many delusions is often nothing but a poorly concealed wish-dream, which by the means offered by the particular disease (hallucinations of the various senses, delusions, paramnesias) seeks to represent the wish as fulfilled—I say seeks to represent, for even in a delirium and in a dream, a person does not always entirely forget that his wishes are confronted by obstacles. The latter become symbolized as "persecutions," just as similar experiences of healthy persons created Ormuz and Ahriman, God and the Devil. (p. 98) Bleuler showed in this paper that the same wish mechanisms are also discernible in organic and toxic psychoses.

This is still true today, but it is also true now as then that the meaning of psychotic behavior is not the same as the cause of the psychosis: in fact, Bleuler and Jung maintained that in schizophrenia, the paradigmatic psychosis is both a psychogenic and a physiogenic, that is, biological disorder, that is, that some toxin is involved, as acknowledged by Freud himself: "As far as I know even today Bleuler maintains the view that the various forms of dementia praecox have an organic causation . . . which takes no account of the libido theory" (Freud, 1914, p. 29). Viewing libido, shorthand for sexuality, as a fusion of physiology and psychology, Freud had no need for other organic theories. More importantly, the "libido theory of the neuroses . . . missed by the Swiss investigators" (p. 29) was *the* keystone of his theory of schizophrenia. Therefore, the other Swiss investigator, "[Jung] (1912) . . . came to grief on this same point" (p. 29), having abjured Freud's sexual libido theory by replacing it with a Bergsonian kind of energy. Actually, as a result of Jung's heresy, both Freud and Jung came to grief, their regrettable historic schism. Most surprisingly, in 1914 Freud referred to his 1896 case of paranoia but not to Schreber. For it was in his 1911 analysis of Daniel Paul Schreber's (1842-1911) book, not a case he treated, that Freud expanded the 1896 dynamics by the sexual theory of psychosis as caused by fluctuations of an energy called libido. The first to apply psycho-

analytic concepts to the treatment of schizophrenic inpatients was the Zurich school member Maeder (1910) and the first clinical study connecting homosexuality and paranoia was published by Ferenczi (*italics in original*, 1911).

Freud's libido was never scientifically verified as a biological energy while the hypothetical flows of libido, let alone homosexual libido, were fiction and metaphor, while Schreber's multifarious hallucinations and delusions were reduced to a "simple formula" (1911, p. 41), thus freely mixing energetics with exegetics. However, on Freud's own showing, the question why Schreber yearned when he did for a passive homosexual gratification from his psychiatrist Paul Flechsig (1847-1929) could "not be answered in the absence of more precise knowledge of the story of his life" (p. 46), so that "anyone who was more daring than I am in making interpretations, or who was in touch with Schreber's family and consequently better acquainted with the society in which he moved and the small events of his life, would find it an easy matter to trace back innumerable details of his delusions to their sources and discover their meaning" (p. 57). As an explanation, Freud's theory of Schreber's illness, a shibboleth for generations of psychoanalysts, could not stand; furthermore, Freud did not consider aggression, at least not for another decade or more (Lothane, 1992; for a complete bibliography see Lothane, 2010a).

Bleuler (1912) was the first to claim that Freud's sexual interpretations of Schreber's delusions could not be considered a cause of his psychosis. And so did Jung, with whom Arlow and Brenner agreed in 1969. Analytically informed historians Macalpine and Hunter (1988) also doubted the importance of Schreber's homosexual fantasies in favor of procreation fantasies:

Schreber's behavior cannot be understood in phallic or genital terms, nor in terms of libidinal drives directed towards other persons. It is very different from homosexuality in which a man qua man desires sexual relations with another of the same sex. Clearly passive homosexual urges, whether conscious or unconscious, should be sharply distinguished from the confusion about their own sex invariably found in schizophrenia . . . the more overt . . . [the] transvestitism, the less frankly psychotic the patient, a view supported by the course of Schreber's illness. (pp. 404-405)

Thus, Freud's linking paranoid delusion with unconscious homosexuality was a valid but not a universal formula and it did not apply to Schreber. Another doubt Macalpine and Hunter expressed was about the healing effectiveness of Freud's interpretations: "had Schreber been in psychotherapy and given the accepted interpretations of

unconscious homosexual wishes . . . it is anybody's guess what might have happened to him" (p. 410); "the lack of psychotherapeutic success with psychotic patients, as well as the lack of advance in theory, is due to adherence to the libido theory of psychiatric symptom formation" (p. 406). In spite of his own reservations, Brill (1944) remained loyal to Freud: "I have seen many cases of paranoia since 1911 . . . [with] the basic mechanisms expressed by Freud. But whether Freud's concepts have been fully verified by others does not really matter" (p. 139).

Freud himself said nothing about applying his formulas in the psychotherapy of Schreber and claimed that Schreber healed himself: "*The delusional formations, which we take to be the pathological product, is in reality an attempt at recovery, a process of reconstruction*" (italics in original; 1911, p. 71), on which Brill (1944) commented as follows:

Such a dereistic [Bleuler's term for detachment from reality] state which is a precipitate of the psychotic struggle, is according to Freud, in itself a sort of adjustment or an unsuccessful effort at integration. Freud preferred to leave it undisturbed, he did not at first advise analysis in such cases. He reasoned that as the dementia praecox was in itself a sort of adjustment, albeit morbid, if it were destroyed the patient would be left without any support whatever. But when I discussed this problem with him later, I was pleased to learn that he no longer entertained this view. On the contrary, he felt that in time we would develop a psychoanalytic therapy of the psychoses. (p. 97)

Freud's reply to Brill can be seen as a nod of approval, if Brill needed any, but Freud changed his mind again in the 1916 *Introductory Lectures*:

Sufferers from narcissistic neuroses [i.e., people with psychosis] 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—the revival of the pathogenic conflict and the overcoming of the resistance due to repression—cannot be operated with them. They remain as they are . . . We cannot alter this in any way. (p. 447)

This departure from Freud's account of the treatment of the paranoid woman in 1896 was rebutted by the successful therapy of a paranoid woman by Poul Bjerre (1911) and Spielrein's (1911) inpatient case. But the contested interpretations do not detract from the 1911 essay's *methodological* yield: the developmental dynamics of psychosis, of personal-

ity and character, all lacking in Kraepelin's descriptive and diagnostic formulations of psychosis, and thus a prolegomenon to Freud's theory of narcissism and ego psychology. This lasting contribution to psychiatry was magisterially set forth by Arlow and Brenner (1964). They omitted discussing any homosexual issues in Schreber but instead focused on his world destruction fantasies as an expression of a psychotic detachment from reality and the restitution of this vital contact in the form of delusion and hallucinations, as stated by Freud (1911, p. 71, above), and also underscored the role of aggression (Arlow & Brenner, 1964, chapter 10, pp. 144-178).

Relevant to this discussion is Freud's monadic definition of neuroses and psychoses as a product of the person's inner conflict to be treated by the analyst's interpretations. Freud does not say in the preceding 1916 passage what else the analyst contributes to the interaction with the sufferer, what else promotes change, what is the emotional reaction of the analyst to the psychotic patient and the transference/countertransference interchange. This reflects an unresolved split in Freud between the psychoanalytic theory of disorder and the psychoanalytic theory of therapy. The theory of therapy, as stated in the *Studies on Hysteria* and the 1912-1915 papers on technique, was from the start dyadic, with the analysand and analyst engaged in the psychoanalytic dialogue and process. Therapy was inherently interpersonal, a two-person psychology whereas the theory of disordered behavior was predominantly intrapersonal, a one-person psychology. Sullivan, on the other hand, even as he was influenced by Freud, developed a *unified transactional and dyadic theory of disordered behavior and treatment*, formulated in terms of interpersonal relations. Here is a brief sketch of the evolution of interpersonal approaches to psychosis.

It was the Americans who decisively proved Freud wrong. Freud's prophecy concerning the future of the psychotherapy of the psychoses came true: it flowered neither in Austria nor in Germany but in the United States thanks to Meyer, White, Jelliffe, and Sullivan, to become an American specialty. In fact, Adolf Meyer's concepts of schizophrenia even preceded those of Bleuler:

There is another historical fact which is insufficiently known, although it may explain the comparative indifference with which Bleuler's concept was received in the English speaking countries. Adolf Meyer's theories of reaction types and habit deterioration, implying a rejection of Kraepelin, preceded Bleuler's concept; Meyer (1906) stated his views in a symposium on dementia praecox at the Annual Meeting of the British Medical Association at Toronto in 1906. His address contained in a nutshell practically the whole of his teachings. This article was known to Bleuler. Meyer's intervention in the discussion of dementia praecox several years before

Bleuler had completed his work of modernizing Kraepelin was decisive for American psychiatry. Bleuler's monograph was translated into English only a few years ago, when Meyer's influence was already on the wane. (Stengel, 1957, p. 1174)

This had also been stated by Sullivan (1933, p. 301). Meyer's ideas flourished after he came to the U.S. in 1892: his work as a psychiatrist at Illinois Eastern Hospital, switching from heredity to childhood factors in growth and to a common sense approach to disorder. As director of the Worcester Insane Hospital where he influenced Isador Coriat, the future founder of the Boston Psychoanalytic Institute and participated in the historic Clark University 1909 celebrations where he met Freud, Meyer read a paper on "A dynamic interpretation of dementia praecox" (Hale, 1971). Meyer's psychobiology was optimistic, holistic and dynamic, he conceived illness as a longitudinal, or diachronic (as compared to Kraepelin's approach which was cross-sectional, or synchronic) development, calling for the study of the patient's life history as a sequence of reactions to life's traumas and crises, from earlier precursors, such as habits (a concept taken from William James, 1890) and up to onset of the overt illness. His concept of reaction types was enshrined in the diagnoses of the 1952 *DSM-I*: e.g., schizophrenic reaction, paranoid type, manic depressive reaction, depressed type. In the 1968 *DSM-II* Meyer's classifications—and, by implication his approach as well—were changed to schizophrenia and manic depressive illness. From *DSM-III* on the return to Kraepelin's descriptive psychiatry was complete.

Theodor Lidz (1966), a Yale psychiatrist and psychoanalyst, captured Meyer's influence on psychotherapy:

His influence is still very much alive: not only in his students but virtually in all American psychiatrists. It enters in the way we talk to our patients and conceptualize their problems; in the way we think about personality development and the nature of psychiatric disorders; and, indeed, why we are interested in the person and his life experiences rather than, as so many of our continental colleagues, primarily in a disease process. (1966, p. 321)

Based on the fact that the family is a social system, investigator Lidz (1967) found that

the family environment in which schizophrenics grow up [has] pertinence to the etiology of schizophrenia. . . . the disturbed family milieu is a major factor . . . One of the ways of achieving objectivity in psychiatry is to get rid of content. . . . I do not consider schizophrenia to be a disease but

rather a severe aberration of development. . . . Familiarity with roles and institutions is also an essential part of interpersonal communication and interaction. (pp. 133, 134, 135)

Here was a Freudian speaking like a Sullivanian.

Meyer's initiatives were powerfully supported by St. Elizabeths Hospital superintendent William Alanson White (1870-1937) and White's life-long friend Smith Ely Jelliffe (1866-1945; D'Amore, 1976). In 1913 they founded *The Psychoanalytic Review* and in 1915 published *Diseases of the Nervous System: A Text-Book of Neurology and Psychiatry* (1919, 6th edition 1933), the first to include psychoanalysis. White further elaborated a synthesis of psychiatry and psychoanalysis in two books (1916, 1917). Freud was aware of his reception in America:

The narcissistic disorders and the psychoses related to them can only be deciphered . . . through the analytic study of the transference neuroses. But our psychiatrists are not students of psycho-analysis and we psychoanalysts see to few psychiatric cases. A new race of psychiatrists must first grow up who have passed through the school of psychoanalysis as a preparatory science. A start in this direction is now being made in America. (1916-1917, p. 423)

In 1934 physicians and lay people in Washington, D.C. honored White for his leadership in psychiatry and psychoanalysis by establishing the William Alanson White Foundation, co-founded by Ferenczi's analyst Clara Thompson (1893-1958), which in 1938 started to publish the journal *Psychiatry*. These developments paved the way for the emergence of what came to be known as the Washington School of Psychiatry, whose most prominent representative and director from 1936 to 1947 was Harry Stack Sullivan (1892-1949). The school informed the work of private psychiatrists and those who treated psychotic patients in the Sheppard Enoch Pratt Hospital and Chestnut Lodge. It later inspired the founding in 1930 of the Washington-Baltimore Psychoanalytic Society and Institute (Burnham, 1978; Noble & Burnham, 1969). The New York branch of the WAW Foundation was established in New York in 1946 and renamed the William Alanson White Institute (WAWI) by Clara Thompson, who served as its first and long-time president. The co-founders were Sullivan, Erich Fromm, Frieda Fromm-Reichmann, and David and Janet Rioch. Psychoanalytically oriented work with psychotic patients was also practiced in such famous long-term hospitals as Chestnut Lodge in Maryland, where Fromm-Reichmann (1889-1957), Harold Searles, and Otto Will were staff members, the

Menninger Clinic in Topeka, the Austen Riggs Hospital in the Berkshires, and Hillside Hospital in New York.

Sullivan led the way in numerous papers and books: *The Interpersonal Theory of Psychiatry*, *The Psychiatric Interview*, *Schizophrenia as Human Process*, *The Fusion of Psychiatry and Social Science*, published under the auspices of The William Alanson White Foundation, and other works, edited by Helen Swick Perry who in 1982 authored a standard Sullivan biography. In contrast to Freud's divided approach to disorder and therapy, Sullivan (1931), while a self-proclaimed Freudian, showed that the symptomatic behavior of the psychotic was an interactional product:

In brief, schizophrenia is meaningful only in an interpersonal context; its characteristics can only be established by a study of the interrelation of the schizophrenic with schizophrenic, less schizophrenic, and nonschizophrenic others . . . a fundamental basis for classification: the nonschizophrenic individual, in his interaction with other persons, behaves and thinks in complete consonance with their mutual cultural make-up. Then, to the extent that one's behavior and thought in dealing with another diverges from the mutual culture—traditions, conventions, fashions—to that extent he would be schizophrenic. This seems to be a good working hypothesis . . . It is to be noted that the basic formula of all psychotherapy is that of interpersonal relations . . . the infantile and early childhood experiences [lead to] a consideration of the *interpersonal requirements* for the successful therapy of the schizophrenic. . . . The only tools that have shown results that justify any enthusiasm in regard of the treatment of schizophrenia are the *psychoanalytic* procedures and the *socio-psychiatric* which the writer has evolved from them. . . . The achievement of this double process requires the establishment between the physician and the patient of the situation called by Freud transference. (pp. 277, 281, 283; emphasis Sullivan's)

Reprinted in the volume edited by Perry, this paper contains an interesting discussion by Silverberg, Zilboorg, and Brill. Sullivan underscored the interpersonal function of the Freudian notion of and modified Freudian psychotherapy by adding the cultural and social dimensions of psychopathology which called for a socio-psychiatric rebuilding of the patient's shattered social adjustment, with a stance of hopefulness. Central to Sullivan's (1954) method were the concepts of (a) participant observation and (b) reciprocal emotion. (1) A participant observer is not a detached observer, not like a medical objective and descriptive observer, he cannot merely "stand off to one side and apply his sense organs . . . his principal instrument of observation is his self—his personality, *him* as a person" (p. 3), oscillating between what is actually observed and what is inferred, "concentrating his attention

on the processes going on between himself and the other person, or involving himself with the other person" (p. 58). (2) In any encounter, the interviewer or therapist and the patient are engaged in a process of reciprocal emotion: "(1) complementary needs are resolved (or aggravated); (2) reciprocal patterns of activity are developed (or disintegrated); (3) foresight of satisfaction (or rebuff) of similar needs is facilitated" (p. 128). For the process to go forward the needs of both have to be met, further detailed on pages 129-133. The best exposition of participant observation has been offered by Havens (1976), who showed how this applies to the treatment of psychotic patients by two therapists supervised by Sullivan himself. A splendid recent biography of Sullivan is by Conci (2010), the Italian original reviewed by Lothane (2002).

Sullivan's method was vigorously applied by the pragmatic, empathic, and wise Fromm-Reichmann (1954) in her academic lecture read at the 110th meeting of the American Psychiatric Association. She underscored the prominent role of hostility among the

multiple meaning of many schizophrenic symptoms and communications. This realization should make us replace the old therapeutic attitude that therapists ought to be able to find and offer to the patient the only correct meaning of a symptom or communication by the suggestion that they should train themselves to become able to feel which of the several meanings (if they catch several of them) is the therapeutically most significant one at a given time. (p. 417)

Her approach was endorsed in papers of three discussants of her lecture, John C. Whitehorn of the Phipps Clinic of the Johns Hopkins Hospital (pp. 420-421), Oskar Diethelm from the Payne Whitney Clinic of Cornell University Medical College (pp. 422-425), and Elvin Semrad (pp. 426-427), later Director of Psychiatry at Massachusetts Mental Health Center, professor of psychiatry at Harvard, and training analyst at Boston Psychoanalytic Institute (pp. 426-427). Semrad co-authored a book on the treatment of psychosis (Semrad & van Busirk, 1969).

Paul Federn (1952) made an important contribution to the psychoanalytic treatment of schizophrenia; he had discussed the dramatic direct analysis of John Rosen (Federn, 1947). As noted by Arieti (1959), Sullivan, Fromm-Reichmann, and Rosen influenced Gaetano Benedetti (b. 1920) who joined the staff of the Burghölzli in 1947 to become a leader of the psychoanalytic and existential treatment of schizophrenic patients (1987, 1992). In 1956 in Lausanne, with Christian Müller, he founded the International Symposium for the Psychotherapy of Schizophrenia (ISPS), continued by the International Society for the Psychological Treatments of the Schizophrenias and other psychoses. ISPS-US

was launched in 1998 by David Finesilver, as whose presidents served Ann-Louise Silver, M.D. and Brian Koehler, Ph.D.

Melanie Klein (1946) and her followers were another school that addressed the treatment of psychosis and near psychosis. Klein departed radically from Freud's theory of paranoia in her theory of the infant's paranoid-schizoid position at age four and the depressive position at the age of six months, the basis for her constructing interpretations based on the role of aggression and aggressive fantasies inspired by Abraham's developmental theory and Freud's death instinct hypothesis. Another contribution was made by Jacques Lacan (1977) and his school. Both Klein and Lacan disregarded Freud's sexual theory of psychosis. Abraham's theories of character formation bring us to the contribution psychoanalysis has made to the treatment of character and personality disorders.

The psychoanalytic treatment of psychosis has been an important tradition in the American Academy of Psychoanalysis. As noted by Silver and Cantor (1990) in their introduction to an entire issue of the *Journal of the American Academy of Psychoanalysis*,

the topic of psychoanalysis and psychosis seemed especially fitting since this was an area of intense interest to some of the founders of the Academy. Among the charter members of the Academy who were from Washington were Chestnut Lodge's Dexter Bullard, Sr., Frieda Fromm-Reichmann, Edna Dyar, and Janet Rioch, a popular supervisor at the Henry Phipps Clinic of the Johns Hopkins Hospital, was the Academy's first president. (p. 2)

A crimson thread running through the evolution of the treatment of psychosis was the age-old debate between biogenesis versus psychogenesis of psychosis and near psychosis, as discussed by Giovacchini (1993), who, among others, paid tribute to the contributions of Harold Searles (1965). The contribution made by psychologists is discussed in an overview by Ver Eecke (2002). This debate became more poignant with the growth of neuroscience as analyzed by Silver and Larsen (2003), editors of another special issue, Number 1 of the 18th volume of the *Journal of the American Academy of Psychoanalysis* devoted to psychotherapy of schizophrenia.

Character, a person's distinctive mental and moral attributes, and temperament, the individual's style of experiencing emotions, moods, and desires, have been known since time immemorial in everyday life and in literature. Disorders of character were latecomers in psychiatry. In transitioning from symptom neuroses to character neuroses the "first 'psychoanalysis of character' was developed, namely, the analysis of

the purpose and the historical genesis of certain attitudes as defenses" (Fenichel, 1945, p. 463, referring to Wilhelm Reich, 1927 paper on the technique and interpretation of resistance analysis and to his *Character Analysis*). Gabbard (2009) corroborated Fenichel: "It was Wilhelm Reich (1931) who was the true trailblazer in the psychoanalytic understanding of character. He developed the term *character armor* to describe the unconscious and ego-syntonic defensive style of patients who came for analytic treatment. He postulated that childhood conflicts were mastered with specific defense mechanisms" (p. 185). With this psychoanalysis made a lasting contribution to various psychiatric personality disorders. A growing concern for psychiatrists has been the borderline personality disorder (BPD), the old formerly called pseudoneurotic schizophrenia by Hoch and Polatin in 1949. A series of article in the May 2009 issue of *The American Journal of Psychiatry* underscored the essential complementarity of the descriptive and the dynamic in psychiatric, psychoanalytic and psychotherapeutic approaches to BPD.

In an editorial Otto Kernberg and Robert Michels (2009) pointed out that "neurobiological and psychological structural assumptions correspond to clinical and empirical research data, but we still have to clarify how neurobiological disposition and structures relate to psychological development and its derived structures" (p. 506) and that this "polarity . . . also permeates questions regarding alternative treatment strategies with borderline patients" (p. 507). They cited the effectiveness of transference-focused and mentalization-based psychotherapies and dialectic behavior therapy in helping patients overcome interpersonal "subtle and permanent features of their difficulties in work, love, social life, and creativity" (p. 508), lost in the current descriptive classifications. From a biopsychosocial perspective Oldham (2009) addressed issues of heritable and constitutional "endophenotypes of affective dysregulation and impulsive aggression," correlated with "interpersonal hypersensitivity" (p. 509), and emphasized that "however clear we may be about . . . biological vulnerability to characteristic symptomatic behavior such as self-injury, this behavior has meaning as well" (p. 509), as illustrated in the treatment of a patient in a case history by Goodman et al. (2009). In their treatment-centered article Gabbard and Horowitz (2009) recommended a two-pronged approach: (1) from the "six forms of psychotherapy that have demonstrated efficacy in randomized controlled trials" they "confine[d] their discussion primarily to mentalization-based therapy and transference-focused therapy, the two explicitly psychodynamic therapies" and (2)

suggest[ed] that a false dichotomy is made between an exclusive focus on transference interpretation as the mode of therapeutic action and an

avoidance of transference interpretation in favor of focusing on strengthening the therapeutic relationship . . . that it is the juxtaposition of an increasingly well-defined therapeutic alliance with inevitable transference enactments that helps clarify problematic ideas and feelings and provides a here-and-now situation in which the patient and therapist can together negotiate how to counteract them with more adaptive (because realistic) ones. (p. 518)

A solution for the difficulties in the just cited dichotomy is provided by dramatology (Lothane, 2009) and interpersonal drama therapy (IDT) (Lothane, 2011). Interactions and enactments are consciously experienced and directly observed, unconscious transferences are discovered through dynamic and psychoanalytic exploration. IDT is based on the primacy of first carefully observing, followed by cautiously interpreting, as illustrated in the clinical example.

The young woman “with a borderline personality disorder” in the case reported by Glen Gabbard and Mardi Horowitz (2009) became enraged at a store clerk who refused to accept her credit card, shouted, and felt humiliated as “she made a spectacle of herself.” She “would not have shouted except that the clerk was rude and curt with her” (p. 517). She then got furious at her therapist for asking whether the clerk was followed store policy or that he refused her card. The patient felt humiliated. The therapist interpreted the event in the store as the same thing that was happening with her and him. Detailed process notes would undoubtedly show more than an abbreviated vignette. Perhaps creating emotional storms was a long-standing character habit, the store clerk evoking a reaction similar to others in her past. The clerk was described as rude and curt, and if the woman was correct, then she was right to expect sympathy for how she suffered and therefore became enraged at the therapist’s well-intentioned question. The episode could be seen as a double enactment, in and out of therapy, in response to an interpersonal drama, that is trauma. From the perspective of enactment, the clerk and the therapist were actual, real, encounters, acting as dramatic day residues for the emotional storm in both situations. The reality of the encounter in the here-and-now is acknowledged first, prior to any rush to diagnose or interpret transference. A preferred sequence would be: first commiseration, followed by clarification, and finally confrontation, building up to interpretation, a conjoint activity of patient and therapist. An essential component in dramas in real life and on stage, confrontation thus emerges as a basic therapeutic technique. The issue here is one of a therapeutic philosophy, strategy and

tactic which I named dramatology (Lothane, 2009, 2010b, 2010c, 2011), the application of the dramatic concept to life, disorder, and therapy. This approach is valid in the treatment of both character disorders and psychotic disorders.

Confrontation is not in Gabbard and Horowitz as a technique but is mentioned in an article in which Otto Kernberg is a co-author (Levy et al., 2006) cited in their references. More explicitly, Gabbard (2009), comparing Kohut and Kernberg, favored Kernberg, the originator of transference-focused psychotherapy (Kernberg, 1975, 1984): Kernberg, among others "Helps patient see his or her own contribution to problems in the relationships, Confronts and interprets resistance as defensive maneuvers, Examines both positive and negative aspects of the patient's experience, Focuses on envy and how it prevents patient from acknowledging and receiving help" (p. 199); "he would see the goal of psychoanalysis as much broader than Kohut's" (p. 200). Some therapists still view confrontation as harsh or punitive, but no technique, however empathic and supportive, can prevent emotional storms from happening. First, there will be many unconscious reasons for enactments by both patient and therapist. Second, the most meticulously crafted transference may contain his/her unresolved countertransference. Finally, it is the patient who needs to confront his/her own maladaptive patterns of behavior, and for this he needs the psychotherapist's confrontation to gain such awareness.

In recent years the term "transference enactment" has been preempting the previously dominant acting out which Freud discovered in the Dora case and enshrined in his papers on technique. Marcus (2003), experienced in working with near-psychotic, namely, borderline, patients has offered important insights on action, acting out, and enactment. The *Oxford English Dictionary* defines "enact": "5. To represent (a dramatic work, a 'scene') on or as on the stage; to personate (a character) dramatically, play (a part); also *fig*[uratively] with reference to real life; = ACT." It follows that all people, with diagnoses or without, act in accordance with who they are as characters or personalities, as suggested by Marcus (2003), a psychiatrist and psychoanalyst experienced in treating psychotic and near psychotic patients:

Borderline patients have an action style that is an extreme example of milder forms of behavioral ego styles. A variety of patients have this behavioral style, including some normal people who are not involved in extremes of neurotic "locks" in their life. Some people need to experience their behavior in order to experience their feelings and thoughts. . . . A better name for this kind of healthy action might be *acting through* rather than *acting out*. (pp. 340-341; emphasis Marcus's)

In his treatment method Marcus has combined Freud's dream psychology with ego psychology as articulated by Arlow and Brenner (1964). Marcus launches his theory of action (2003) showing that

enactment is dynamically meaningful behavior which analysts sometimes restrict to transference behaviors of defense resistance. . . . The problem of action, therefore, and its relationship to pathology is a separate question from the question of action itself. . . . The crucial factor is that . . . that behavior occurs in the real world and . . . and reality experiencing capacities of the mind Three categories of motivation for all dynamic action are the experiential motive, the defensive motive and the mastery motive . . . the various *mastery* motives for the wish to change the *day residue*." (pp. 132, 133, 136, 137; second emphasis added)

Day residue analysis occupies a central role in Marcus's treatment method and is much less concerned with transference interpretations. Just as

dreams, which build their images . . . around events that occur during the day . . . conscious reality events, [so] often the day residue in psychosis and near psychosis is . . . a bridge between reality and fantasy, present and past, secondary process and primary process . . . a crucial point in the structure of both dreams and delusions. . . . A day residue is meaningful not just because it happened, but also when it happened and what else was happening or not happening. (pp. 23-25)

For Marcus reality is external reality of the real world and events are encoded in dream or delusion, citing Freud's 1907 analysis of Jensen's novella *Gradiva*, such that the final product, the delusion, an event in its own right, contains a kernel of truth, a hidden reference to the "reality event, with its sequences and contexts that is meaningful and therefore a reality evoker of affect and of symbol" (p. 112). In near psychosis, the day residue "can be an event in reality that seems dramatic or minor . . . but never minor to the patient" (p. 117). Marcus is of two minds about confrontation: he prefers "the term *active questioning* to the more standard term *confrontation*, because confrontation often implies, especially to the beginner, an aggressive stance or attitude" (p. 144), but when discussing reality testing "in the behavioral enactment of the borderline" he avers that "the key to the technique . . . is the clinical judgment about when, where, and with what degree of neutrality, and with what degree of affect. Remember that *confrontation* is a technical term meaning to engage the patient's attention to and interest in the

issues. It does not necessarily imply countertransference aggression" (pp. 321-322; all emphasis Marcus's).

We need to eschew both ideological extremes: psychophobia among neuroscientists and biophobia among psychodynamic psychiatrists, and strive for an integration of biology and psychology as demonstrated in the works cited. Neuroscience seeks to *explain* the biological causes of psychosis as a constitutional bodily *condition* while drug therapy helps control target behaviors, such as, violent aggression. Psychoanalytic psychology seeks to *understand* the person, the person's *conduct* and the *content* of the various hallucinations and delusions as well as their *intent*—in short, the person as acting, adaptively or maladaptively, in an evolving life's drama, in search of love, truth, and justice. We need both to be effective healers of the suffering person.

Let Schreber's case serve as an example. Prior to his second psychiatric admission in 1893 and during an interview with Prof. Flechsig, the latter "developed a remarkable eloquence [. . . and] spoke of the advances made in psychiatry since my first illness, of newly discovered sleeping drugs, etc., and gave me hope of delivering me of the whole illness through one prolific sleep" (Schreber, 1955, p. 65), which had struck the patient as one of Flechsig's "*white lies* . . . hardly ever appropriate in my case . . . a human being of high intellect, of uncommon keenness of understanding and acute powers of observation" (p. 62). Psychotherapy, which Schreber sorely needed, was not part of Flechsig's treatment plan. "About the fourth or fifth night after my admission," tells Schreber,

I was pulled out of bed by two attendants in the middle of the night and taken to a cell fitted out for demented (maniacs) . . . [and I] was naturally terrified in the extreme by this event . . . the following morning Professor Flechsig's attendant appeared . . . he tried to raise my spirits again [. . . which] had the effect of a very favourable change in my mood. I was led back to the room I previously occupied and spent the best day in the whole of my (second) stay in Flechsig's asylum, that is to say the only day on which I was enlivened by a joyful spirit of hope. (pp. 66-67; emphasis Schreber's)

It was, perhaps, the only day the patient was offered psychotherapy. While incarcerated in Sonnenstein, Schreber would warn psychiatry not to "tumble with both feet into the camp of naked materialism" (p. 90).

Schreber's warning is timely in view of the continuing crisis of psychiatry; its being retooled as a branch of neurology and a growing

reliance on drug treatments with dwindling support and reimbursement for psychotherapy. In the zeal to reduce the person's thoughts to things, for example, the brain and its parts, let us be reminded of Buber's (1958) message: "The primary words are not isolated words, but combined words. The one primary word is the combination *I-Thou*. The other primary word is the combination *I-It*. . . . Hence the *I* of the man is twofold. For the *I* of the primary word *I-Thou* is different from that of the primary word *I-It*" (p. 3). In the course of our life's dramas we have various *relations* to things, that is, objects, but interact in *relationships* with persons, in *interpersonal* relationships (not, perish the word, in object relations!), as defined by the immortal Sullivan.

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