

well known, have little to offer with regard to modern and more or less time-consuming psychotherapeutic procedures. Mental therapy as it is available in the out-patient departments is still pitifully inadequate. Private physicians engaged in the practice of psychotherapy (psychoanalysis) offer optimal service in treating neuroses and similar conditions; however, as they have only a few hours at their disposal, they are unable to take care of many charity patients.

The Veterans' Administration in full appreciation of its responsibility toward the returned soldier recognized the inadequacy of the present-day hospital facilities (including their own), particularly the services rendered by the out-patient departments. A great number of specialists were authorized to treat veterans in their private offices. Thanks to this arrangement, many neurotics who never would have been afforded a prolonged psychotherapeutic care, are now able to benefit by it at the Government's expense.

But what about the millions of others?

Here the difficulties appear insurmountable. And yet the task of collecting the necessary funds must be undertaken. The Psychiatric Foundation is the logical agency for organizing such a campaign, and we hope it will soon make important decisions in this matter.

PRINCIPLES OF PSYCHOTHERAPY IN LATENT SCHIZOPHRENIA*

PAUL FEDERN, M.D.
New York, N. Y.

I. THEORETICAL CONCEPTS

Scientific psychotherapy is based on the understanding of the conscious and the underlying unconscious psychological disturbances. While the mechanisms of neurosis are well known, those involved in the schizophrenic process are still controversial.

Every psychosis is a mental disease of the ego itself, while in neurosis only some functions of the ego are impaired. In psychosis, the main damage consists of the loss of cathexis (mental energy charge) of the ego boundaries (1). As a consequence, we find in this condition a narrowing of the extent of the mental ego, ideas and concepts being still preserved. But the same ideas which normally form within the mental ego boundary and, therefore, are apperceived as mere thought, at once take on the character of a false reality when they occur outside of the ego boundary (2). As the loss of the ego boundary cathexis becomes definite, this false feeling of reality takes on the quality of being beyond any subjective doubt. Yet everyone can observe that frequently with any new schizophrenic production, the ego boundary cathexis oscillates for some time and that the subjective reality of the patient's thoughts is continually interrupted. With every "swing" the patient somehow subjects to doubt the "reality" of his mental productions.

Fortunately, for long periods of time, the loss of the ego boundary cathexis and the subsequent false reality remain only partial. Furthermore, in the majority of cases, losses of cathexis are reversible, and thus the ability of correctly separating ideation from perception can be regained. Therefore, in treatment, those parts of the ego which still function with adequate distinction of thoughts and reality must be employed as allies. Only with their help can the repair of the deficient part be accomplished.

These theoretical considerations are important as a basis for the technique, especially if psychoanalysis is contemplated, whether of the orthodox type or one of the newfangled "brands."

* Presented to the Staff Meeting of the New York Consultation Center on January 30, 1947, and to The Jewish Board of Guardians on March 7, 1947.

In contrast to the situation in neurotics, one cannot, with psychotics, rely upon the ego to differentiate correctly between thought and reality. With the psychotic one must be careful not to raise unconscious instinctual and infantile material into the consciousness. Unfortunately, this is inevitable once the psychosis has been established, since the ego boundaries, deprived of their cathexis, have lost their function of acting as a counter-cathetic agent against the pressure of the unconscious material. Although used in different ways, the means of transference and interpretation are the same in both cases. With neurosis, the psychoanalyst endeavors to make unconscious, repressed material conscious. In psychosis, he has to deal with *too much* unconscious material already brought to consciousness. Thus, the therapeutic aim here is not the release of repression but re-repression. In antithesis to Freud's well known motto: "Where there is Id, let there be Ego," we must say with regard to psychosis: "What has become the Ego's territory should be returned to the Id."

That the re-repression is possible is evident by its spontaneous occurrence after resolved psychotic episodes. To help such recovery two ends are sought by psychoanalysis:

(1) The therapist directs the patient to focus his attention upon his special conflicts which resulted in the breaking through of unconscious material. One part of these conflicts lies in the present reality situation, the other derives from material which previously was repressed. The former conflict is usually neglected and its connection with unconscious conflicts ignored by the patient. When this connection is actively revealed, the understanding of the unconscious part becomes more easily accepted. It is impressive how many resistances of the psychotic are based on definite reality conflicts.

(2) One must encourage the patient to recognize how his previous ego states interfere with his present ones. It is not generally realized by psychoanalysts that, normally as well as pathologically, ego states are repressed; successfully in normal people, unsuccessfully in neurotics and in psychopaths. Psychotic patients are able to recognize this fact; frequently they recognize it spontaneously and better than is possible with most healthy persons.

By virtue of the therapeutic influence, favorable cases react in a gratifying manner. By their own repeated attempts the patients learn successfully to adhere to the normal adult ego state for periods

of increasing length. This concept is similar to that emphasized by Adolf Meyer, in his basic goal, the re-integration of the slowly diseased personality.

Whether infantile ego states are re-repressed or whether they are resolved through active therapy and the healing factor inherent in some psychotic processes, is difficult to say. Such a distinction would answer the pertinent question as to whether his disease is only temporarily arrested, i.e., whether the cathexis of the regressed infantile ego states has been lost again. If we are able to answer this question we could make a reliable prognosis in regard to later relapses.

Neuroses and psychoses are likewise opposed to each other in regard to the ego cathexis. In every case of neurosis, some ego boundaries are too much cathected. This is true with obsessional neurosis in respect to the boundaries between ego and superego (3), and in anxiety hysteria with regard to the boundary between the ego and the objective world. In conversion hysteria, the ego boundaries are enlarged to include some organic expressions into the ego. Some ego boundaries of the hysteric are over-cathected with emotion. Here, too, previous ego states retain an increased cathexis through which they disturb the present ego (4).

Thus it may be summed up, the aim of psychotherapy is to restore lost cathexes to the psychotic ego, and to drain off hyper-cathexes from the neurotic ego. It is, of course, easier to remove superabundant cathexes—by the therapeutic means of transference, catharsis, insight and indulgence of the superego—than to restore missing cathexes. It is likewise less difficult to raise pathogenic and traumatic material from unconsciousness than to re-submerge it into the depths.

The differences mentioned above are explained by another basic—albeit not completely universal—distinction between psychosis and neurosis. It is one of the fundamental and unshakeable tenets of Freud that neuroses are mainly defense phenomena, while psychoses are mainly defeat phenomena of the ego. The latter concept was implicitly stated by Freud in his explanation of the Schreber case (5). The difference is not universal, however, because in every mental disease the conflicts between personality and instinctual drives are fundamental. Furthermore, in psychosis, too, the ego still defends itself against deeper destruction by using all remaining faculties of thought and emotion; in neurosis, the ego is not able to

defend all its functioning unimpaired. Moreover, in both groups of mental illness the ego does not only defend itself against the disease but also accepts it as the source of paranoid and ego gain.

The above theoretical introduction was necessary in order to understand the right procedure with early schizophrenia, *from which latent schizophrenia is sharply separated*. The therapeutic aim is to prevent a latent schizophrenia from becoming a manifest one. For this reason the diagnosis of latent schizophrenia should be made early. Even though it may be impossible to prevent the outbreak, the attempt is worth our while since the outcome of schizophrenia is unpredictable in any case.

Most schizophrenics take a chronic course. The personality disintegrates slowly, reality perception still controls the more important falsifications, and a rather good adjustment may last for many years with a very slow change to the better or to the worse. Therefore psychotherapy has a good chance to protect an individual against recrudescence of the disease.

Some cases appear not to be malignant, whereas others succumb as though to an actively destructive process. The constitutional forces of resistance, and the scope of extrinsic injuring factors influence the course. Complicating organic factors will be dealt with later. Additional factors are inner conflicts and external emotional strain. In favorable cases precipitating causes are usually less strong than in those ending in hospitalization. The psychiatrist, therefore, has to advise the responsible relative, the family doctor or the social worker that a relapse is possible. Conditions which were adequate for the patient when he returned home from the institution may later become inadequate and thus harmful—because the schizophrenic himself has changed, either to a lower or to a higher level of integration.

Schizophrenia always interferes with personality development; no schizophrenic individual has matured like a normal person. Therefore we must deal with the schizophrenic patient on the level of his mental and emotional age.

II. PRACTICAL CONCEPTS

Psychiatry has successfully explored the pathological mental processes and the individual disturbances due to the schizophrenic disease. Unfortunately, one does not know the nature of the

pathogeny itself. Although our methods of therapy, including shock treatment, do not attack the pathological cause, they offer more than a merely symptomatic relief, because they improve the conditions of fight between pathological process and defense.

In those instances in which a latent schizophrenia becomes manifest one can observe exactly a dynamic struggle between health and illness; health represented by the normal parts of the personality and illness represented by those parts which have lost their normal cathexis, especially that of the ego boundaries. Our support of the healthy structure as well as of the diseased parts of the ego may arrest any further loss of cathexis. When the struggle against the first delusional threats with the subsequent anxiety in the deranged portion of the ego ceases, the strain on the healthy part also diminishes. In favorable cases it soon becomes evident that the diseased part is better controlled and guided by the healthy one.

The main help given to both parts is the establishment of a positive object libido transference, and also of an identification with the helping personality. To the patient, transference as well as identification are gratifying and pleasurable conditions. Transference helps directly insofar as it increases object interest and channels libido away from an exaggerated narcissism.

The well-known transference improvements are as frequent in psychotics as in neurotics. Through transference and identification the patients become less vulnerable. There is a difference in the technique we apply to neurotics and to psychotics inasmuch as in neurotics we attempt to dissolve the transference and do not allow it to increase, whereas with psychotics one must preserve the positive transference, and avoid provoking a negative one (6).

The patient needs his whole libido to maintain his imperiled functions. Therefore, in some cases, we have to be cautious in our use of transference; often the patient is induced not to direct his energy to objects, for instance, to occupational therapy or to a job, lest this pursuit increase the narcissistic satisfaction, and ultimately lead to more dissatisfaction. One must be careful not to disturb this very labile equilibrium.

J. H. W. Ophuijsen¹ has recently characterized the transference taking place in group therapy of various diagnostic categories as a regression to the pregenital level. In pre-psychotic patients we would fear provoking such a regression. When, however, in psy-

¹ Unpublished report on group therapy.

chotics a pregenital level is already established, the transference may begin on this level but it soon progresses to include a genital component. In some respect every well-conducted institution for psychotics uses some group therapy (7). However, many psychotics, even in a group, live as isolated individuals wrapped up in their narcissism.

When the psychotherapist speaks with a psychotic patient he must be aware that the ego levels of the patient are subject to change as are his words and behavior. Transferences and identifications also belong to different ego levels. In transference, the patient may clearly and intelligently discuss his relationship with other people on a normal level, and the psychiatrist may use this situation to reconcile the patient with some of his difficulties. More than with neurotics, the psychiatrist must preserve the positive transference by siding with the patient in any of his conflicts.

Without staring at the patient constantly, one should watch his facial expression to notice any change in his dominant ego state. He may suddenly show some suspicion or an ambivalent feeling toward the doctor or another person; if one does not know the causes of the trouble, the patient himself usually gives his explanation when he is asked to tell about his change of attitude. One should by no means let a patient leave the office without having clarified such a change. It is inadvisable to tell a lie to the patient (even a white lie!) or to camouflage any discord or complaint that may arise.

While only in paranoia does the positive transference create difficulty, identification must in every case be recognized and resolved early, lest the patient in the process of improving, imitate the psychotherapist too much (8). Such a patient might, for instance, want to get married or divorced, or to change his occupation. One must be careful not to mistake such an induced activity for real improvement. However, identification strengthens the healthy part of the ego directly and, in most cases, immediately improves the attitude of the diseased part of the ego. Like the child, the patient feels relieved of anxiety and of conflicts by enlarging his ego through identification with the directing adult person; his willingness to obey, his self-reliance and his striving for normalcy improve (9).

With the help of such good relationship with his patient the psychotherapist cautiously attempts to rectify falsifications, not by criticising them but by asking the patient to enter into all details about his illusions, hallucinations, or ideas of reference—whichever

troubles him the most. Then one may juxtapose one's own explanation of the facts in question without stressing its acceptance. In advanced cases such peaceful criticism usually is ignored; in early cases, sooner or later the patient reacts to it.

One should try to get the patient into psychotherapy at the very beginning of the psychotic phase. Usually, parents, physicians, and educators are slow in recognizing the seriousness of the patient's behavior change. In the anamnesis of the patient we often find that schizophrenia had started with a noticeable deterioration of his school marks at the time of his advanced education (college) or at the time of his work on the first important job. The student's marks in his first year or years were good; suddenly he came home with the order from the college for the parents that he be seen by a physician. If the college psychologist would correctly understand the youth's struggle against his ensuing psychosis which makes his marks as well as his social adjustment decline, the boy would at least be spared the harmful effect of being dismissed from his college. The army did much better than the schools in detecting the onset of the disease.

In elementary and high school, physicians, teachers, and mental health agencies share the task of an early recognition of mental cases. However, psychotic cases are seldom diagnosed as such immediately; they are, in most cases, labeled as behavior disorders or as development problems of the child or the adolescent. Child psychiatry and case work teach us that many pre-psychotic cases of latent schizophrenia in reality are post-psychotic cases. Hence, the early childhood data must be scrutinized very closely. The help of the social worker or the psychiatric nurse is required for this task (10). Later such help is needed to provide a good transference to a person of the opposite sex. My experience, which I published elsewhere, that a good result in an advanced psychotic case cannot be achieved without the help of a motherly woman, should be checked in regard to latent schizophrenia. My guess is that it will be confirmed.

Although the course of the disease is unpredictable, there are certain features and signs which give indication of the probable outcome, as Nolan Lewis has pointed out in a report on advanced cases (11).

Generally speaking, the course depends on (A) the malignancy of the process, (B) the qualities of the personality struggling against

the diseased part of the ego, (C) any additional conflicts as well as any damage inflicted by external factors which increase the strain imposed on the normal part of the personality. These factors work together to provoke the outbreak of schizophrenia. It is clear, therefore, that in treating latent schizophrenia our procedure must be focused on these contributing agents.

Among the pathogenic factors mentioned above, the factor of malignity cannot be reached by our science. What we can do is to strengthen the personality itself and to avoid additional emotional strains on the individual, who is balanced so precariously.

In regard to the malignity of the process it may well be that this factor is not a uniform one. We may incorrectly attribute to the disease some conditions inherent in the organism, which are attacked by the illness. This suspicion is based on the observation of organic occurrences which have precipitated the outbreak. Pregnancy and childbirth in women as well as infectious diseases in both sexes are spectacular in this regard. If the schizophrenia is detected during its latent state, the outbreak may be avoided by properly applied somatic methods and by preventive psychotherapy.

Some schizophrenic processes are initiated and precipitated by intentional reducing or gaining of weight. In most cases this change in weight is to be seen among the first symptoms. In his proprioceptive sensation of the oncoming psychosis the patient is inclined to overdo an otherwise rational dieting. In these cases the bad effect of fasting or overeating is conspicuous. The psychosis begins with disturbances of the body ego and with hypochondriacal symptoms. In other cases thyroid and other hormonal medication precede the outbreak. Joseph Wilder (12) and other authors have stressed the importance of correcting the calcium content of the serum. Hypoglycemia (13) is another avoidable complication which should be kept in mind by the physician. I saw paranoid cases subside under such therapy after shock therapy had failed. Physicians, including endocrinologists, who prescribe endocrine preparations are not familiar with the fact that in some cases the proprioceptive ego feeling is changed by hormonal influence. Such a change makes the individual sensitive to any further loss of the ego boundary cathexis, and thereby may provoke a schizophrenic episode.

Accumulated deficit in sleep is another precipitating source of damage. Chronic use of barbiturates is definitely harmful to individuals with latent schizophrenia. Frequently the manifest schizo-

phrenic case begins in the morning with illusions and hallucinations as residues of a half-dreamy state, into which the patient's ego awakens from full sleep (14). This state of half-sleep is due to an incomplete utilization of sedatives or to the fact that the patient's sleep was terminated prematurely. Such persons should not be allowed to doze on but should be made to arise from bed quickly into wakefulness. In families as well as in institutions the importance of sleep of pre-psychotic cases is seldom adequately evaluated.

A further precipitating cause can be the increase of sexual activity. The hypochondriacal fears of latent schizophrenics in regard to marriage and honeymoon are not unwise reactions to this hormonal danger. Increased sexual activities are more harmful when they are without full satisfaction and deprived of their healthy sleep-inducing effect.

Before the outbreak, slight manifest symptoms may mar the state of latency. For some weeks or months patients appear suspicious, irritable or sentimental, or exalted to a degree, which retrospectively, could be explained by the struggle against their inner danger. How soon a latent schizophrenic may lapse slowly or fall suddenly into the depth of insanity, depends on his emotional strain, his libidinous frustration, and also on the unknown factor of his individual power of resistance. However, there is always a struggle before the ego gives way. The ego uses a variety of defenses to maintain its integrity. The good therapist respects and supports these defenses. This also holds true for defenses of abnormal nature, especially the neurotic or even psychopathic defenses, as far as they can be tolerated. Whenever latent schizophrenia is discovered, it is difficult to decide whether or not one should therapeutically attack a neurotic or slightly psychopathic state which, however, keeps the patient in his equilibrium without leading to a manifest psychosis.

The normal defense consists mainly of the individual's spontaneous avoidance of exaggerated strain. William C. Menninger (15), justly points to the many ways in which people compromise between mental disease and normalcy.

A frequent defense of the individual is the reduction of his activities (Anna Freud) (16), his ambitions, and even the lowering of his social status. One frequently sees an outbreak of the psychosis when the latent schizophrenic, spontaneously or instigated by another person, becomes ambitious to enter into the higher strata.

It is for this reason that some schizophrenics find the rigid and circumscribed conditions in the army easier to endure than those of the civilian life to which they return. Not knowing the harm they may inflict, family and friends demand of the veteran a greater activity. However, this stimulating influence in many families is counteracted by the desire, especially of the mother, to keep her son under her care and guidance.

It is difficult to pilot the family and the latent schizophrenic between these contrasting tendencies without increasing his tension. Generally, slow transition from dependency to independence is better tolerated than sudden steps, even though they may be fulfillments of old fantasies of the patient. The adult can put up better resistance against any broadening of activities than he was able to when he was a child or an adolescent. But even with adults one frequently observes how a schizophrenic episode is set off by the transition to a higher school level, or from school to a job, or to the responsible state of marriage. It is pathetic to witness such consequences of an apparently successful marriage or of a successful career. With older people it is usually the opposite. The breakdown follows divorce, material losses, or some other defeat.

The resistance against responsibilities is related to and combined with too close a family attachment or intense friendship. It is based on a masochistically tainted relation to people. Another group of masochistically oriented ego defenses is that of sublimations: philosophy, religion, anthroposophy, theosophy, and all sorts of esoteric mystical systems. In the latent schizophrenic such "idea systems" are used in a morbid way and their rational as well as their emotional supports can collapse easily. The psychotherapist may become well aware of their morbid nature and may want to remove them. One cannot be too emphatic in dissuading such a beginning.

This leads us to the most important self-defense against schizophrenia, the neurosis, which usually is of the hysterical or the obsessional type. The temptation of the therapist is to interfere by using rational persuasion or psychoanalysis. *No latent schizophrenic should be "cured" of his neurosis, and he definitely should not be treated by the standard form of psychoanalysis.* For thirty years cases have come to me for treatment or for consultation after having been naively, and apparently well, psychoanalyzed. Their (correct) diagnosis was neurosis. During all that time the latent schizophrenic state was not recognized. Seldom did the psycho-

analyst either anticipate the outbreak or acknowledge, after it had occurred, that it was his interference that precipitated the manifest psychosis. He would invariably think the case was too difficult for psychoanalytical treatment. This kind of error is not a personal one, but one made by "standardized" psychiatry. Even Bowman (17) has recently propagated the general point of view that psychosis and neurosis differ in quantity and not in any basic quality.

This writer as well as some other psychoanalysts have written about psychoanalysis modified for use with psychotics. Since then typical psychoanalysis has been used less frequently with psychotic and pre-psychotic cases. Yet it still happens! Therefore it is well to repeat our introductory principle: With neurotics our aim is to make the unconscious conscious, and with psychotics to make the conscious unconscious again. For this reason one must abstain from taking a complete anamnesis from the patient himself, from using the method of free association, and from resolving the positive transference. Furthermore, the patient should not lie on the couch, and not be pressed into infantile ego states. Infantile ego states, immature ideation, unconscious material come up spontaneously.

The therapeutic method with schizophrenics consists of diminishing their emotional conflicts; of cautious interpretation that gives relief; of working-through of the material; of reducing the psychotic and irrational productions to the underlying objective conflicts. With mild or early cases as well as with pre-psychotics, one can achieve good results. The technical innovation does not contradict Freud's teaching, for he developed his method for the treatment of neurosis and not of psychosis. Freud repeatedly said that psychotics were not suitable for psychoanalytical therapy. Today his thesis still holds true when one wants to use the standard method; however, it is no longer true when one knows how to modify it. One should not assume that the modified method is easier and less strict. As Freud said, "one cannot make a reliable contract with the psychotic ego." Therefore, it is only with the greatest precaution that we use a method which brings more psychotic material to the surface. The patient must also be allowed to apply for help, not only at stipulated hours, but whenever his emotional tension demands it.

In recent years John N. Rosen (24) took an important step forward in psychoanalysis of schizophrenia. He successfully treated paranoid and other delusional patients whose fully developed illness was of many years' duration. One group was in the stage of acute

catatonic excitement. His treatment requires irregular hours and even continuous, day-long work. Of course, constant surveillance by experienced nursing is necessary. When his treatment will have become standardized and also when through further discoveries the biological nature of schizophrenia will be better understood, we all may become somewhat less concerned when the latent schizophrenic slides into the manifest psychosis. However, up to the present time it still seems advisable to maintain latent schizophrenia in its latent state.

Latent schizophrenia frequently hides its real nature behind the cover of schizoid or criminal psychopathy. A few words may be said on this topic. The writer's impression is that the schizoid type of psychopathy *protects* the person from becoming schizophrenic when a latent inclination to this psychosis exists. The diminished intensity of all conflicts is what makes for this protection. Yet the psychopath experiences a great many conflicts, even though they may have superficial causes. He reacts to them quickly and with an uncontrolled emotional expression. Therefore, one has less reason to fear that he might provoke a psychosis in these cases by the application of typical psychoanalysis. Unfortunately, however, psychoanalysis in psychopaths is rarely feasible, because it is much more difficult to establish a reliable transference with the schizoid psychopath than with a latent schizophrenic whose psychosis is covered by neurosis. We have not had sufficient experience with this type to give advice because it is so difficult to maintain the transference and the necessary countertransference.

In regard to criminal psychopaths, it is generally known that there the clinical picture is usually combined with neurotic symptoms and neurotic character traits. But the treatment of criminality is not identical with the treatment of the concomitant neurosis; the former is much more focused on fortifying the superego and on normalizing the ego ideal. Success in many cases requires a prolonged identification of the criminal psychopath with the psychotherapist. The same was found by Lindner in his valuable book on hypno-analysis of criminals (25).

Let us hope that psychoanalytic psychiatry will never relax in its justified attempt to enlarge its realm by including psychopaths of all kinds. This attempt was successfully made by Melitta Schmideberg (18) and by her colleagues in England. Prevention of crime, through psychiatric treatment of psychopathy is propa-

gated also by Heinrich Meng (19) in Basle. Every worker in this important field will derive great benefit from the basic work by August Aichhorn (20), the pioneer of a psychoanalytically directed pedagogy. It affords satisfaction to know that the work of Freud and his followers is carried on by the younger generation until the many unsolved problems will be clarified.

Our principal conclusion seems to be rather paradoxical: Do not provoke; do not be active; do not try too vigorously to elucidate the basic conflict; master your psychoanalytic interest and your eagerness to understand your case fully. Postpone your desire to obtain the history of past psychotic episodes. A psychoanalysis with daily sessions, strict rules and, incidentally, high costs is not indicated with these patients. Every experienced psychiatrist of any orientation has learned to deal with these cases. However, as we said in the beginning, a good Freudian understanding of the dynamics, the interplay between urges and defenses, is of the greatest help to the therapist.

By an early diagnosis we may avoid in latent schizophrenia the danger of bringing more unconscious material up to the patient's conscious awareness. An experienced psychiatrist intuitively recognizes the latent psychotic by his behavior, even when a neurosis is superimposed. It is often difficult to describe the characteristics of posture, language, and glare of the eyes. However, a hidden paranoid or catatonic stigma reveals itself by the patient's behavior and his manners earlier than by his verbal productions. Another hint for diagnosis is any information we may obtain about the occurrence of schizophrenia in the family. One feels somewhat reassured when one hears that there has been no psychotic case in the patient's family and that in the third generation the number of children has not diminished abnormally, contrary to the decrease one usually encounters.

In any doubtful case one can ascertain the diagnosis of latent schizophrenia by having a typical trial psychoanalysis of a few days' duration, conducted by a trained analyst. The latent schizophrenic shows an astonishing productivity of free associations pertaining to the typical unconscious sources of anxiety. Frequently, associations are in the line of primary thinking processes, and dream interpretation is accepted without reservations. The most astonishing feature of a trial psychoanalysis is the latent schizophrenic's readiness to use and accept symbolic expression. Such excellent

response frequently induces the therapist to believe that the case is an excellent object for a continued psychoanalysis. Doctor and patient join in their delight with the good progress of psychoanalysis until sooner or later the latent psychosis is brought into the open. It is one of the main purposes of this paper to warn the psychotherapist not to provoke a psychosis in this way but to interrupt immediately the course of a typical psychoanalysis and to return to a method which is more cautious and has re-repression as its goal.

Some characteristic features of free association mentioned above may be evident in an ordinary psychiatric interview. Psychological tests, especially the Rorschach, should be given to confirm or to invalidate the tentative diagnosis. Letters, articles, or stories written by the patient are also of some help, and so are paintings and drawings (21 and 22). Any disproportionate change in their pattern should be regarded as a danger signal.

One should be on the alert for another interesting symptom. Whenever estrangement and depersonalization linger on, the suspicion of a schizophrenic process is justified. But there are individuals where a severe alienation (estrangement, depersonalization) of the inner and outer perceptions persist for years without any progressive disturbance. However, typical psychoanalysis should not be done with them. Every alienation or depersonalization is due to the withdrawal of the libidinous component of the involved ego boundaries while some mental cathexis remains. Therefore schizophrenic changes in either direction are accompanied by temporary states of estrangement or depersonalization. An exception has to be made with the estrangement that is a feature of severe and prolonged anxiety or terror states.

After the warning not to proceed with the usual method of psychoanalysis in individuals suspected of schizophrenia, the problem remains as to what other efficient ways of treatment are available. One useful method is that of sparing, preserving, regulating and also exercising the mental powers of the individual. This seems to be a rather general prescription, but it involves a very distinct, deliberate and direct advice and aid within the limits of mental hygiene. Help is especially needed in regard to the sexual life of the latent schizophrenic. Control of autoerotism, safeguarding the normal intercourse, avoidance of an incomplete satisfaction and adequate contraception are tasks which must be attempted in spite of their difficulty. To assure contraception it may be advisable in some

cases to go so far as to advocate surgical intervention by way of tuboligation or vasoligation, not only because of the eugenic aspect involved, but also because of its desirable hormonal influence (Steinach effect)² (23).

Any treatment of a latent schizophrenic has to last indefinitely. When the patient is able to settle his conflicts, to tolerate his shortcomings and those of others, to bear frustration and to accept reality, the re-educational part of psychotherapy has ended. However, no such patient is out of danger; some contact must continue, and he should know that he can call for help in case of any emergency.

The psychotherapist should not restrict his mental hygiene guidance to the patient only. With the help of the social worker he must improve the mental climate of the whole family, without taking sides unjustly. He is the defender of the patient. Yet, if possible, the psychotherapist or social worker should give psychotherapeutic advice only to one member of the family. Furthermore, it is seldom permissible to discuss the patient's problem with any member of the family or any friend of his, except in the patient's presence; the nearer the patient approaches a psychotic state, the less exceptions to this rule can be allowed. No matter how uncomfortable such restrictions may be, it would be psychologically unsound to take the risk of arousing the suspicion of the patient.

This is true especially in cases where the latent psychosis is expected to begin with ideas of reference and persecution.

BIBLIOGRAPHY

- (1) Federn, P.: Varieties of Ego Feeling, *International Journal of Psychoanalysis*, 1926.
- (2) Federn, P.: Psychoanalysis of Psychoses, *Psychiatric Quarterly*, 1943, Vol. 17, 3.
- (3) Federn, P.: Die Vier Frongesetze der Zwangsneurose (The four rules of "statute labor" in obsessional neurosis), *Internat. Zeitschrift f. Psychoanalyse*, 1933, Vol. XIX, 4.
- (4) Federn, P.: The Determination of Hysteria versus Obsessional Neurosis. *The Psychoanalytic Review*, 1940, Vol. 27, 3.
- (5) Freud, S.: Collected Papers, Vol. III., Psychoanalytic Notes upon an Autobiographical Account of a Case of Paranoia (Dementia Paranoides), 1911.
- (6) Federn, P.: Psychoanalysis of Psychoses, *Psychiatric Quarterly*, 1943, Vol. 17, 2.
- (7) G. Devereux: The Social Structure of a Schizophrenia Ward and its Therapeutic Fitness, *Jour. of Clin. Psychopath. and Psychother.*, Vol. 6, No. 2, 1944.

² This effect has not been accepted generally in the United States.

- (8) Federn, P.: Psychoanalysis of Psychoses, *Psychiatric Quarterly*, 1943, Vol. 17, 1.
- (9) Federn, P.: The Psychiatric Social Worker's Concern with Shock Treatment, *The News-Letter* of the American Assoc. of Psych. Soc. Workers, Vol. 15, 2.
- (10) Gertrud Schwing: Ein Weg zur Seele des Geisteskranken (An approach to the mind of the psychotic), Raschers Verlag, Zurich, Switzerland, 1939.
- (11) Nolan C. Lewis: The Prognost. Signif. of Certain Factors in Schizophrenia, *Journ. of Nerv. & Ment. Dis.*, Vol. 100, p. 414, 1944.
- (12) J. Wilder: Organtherapie in Psychotherapie, *Nervenarzt*, Vol. III, p. 152, 1930—and: Psychological Problems in Hypoglycemia, *Am. Journ. of Digest. Diseases*, Vol. 10, p. 1, 1943.
- (13) Franz Alexander & Sidney A. Portis: A Psychosomatic Study of Hypoglycaemic Fatigue, *Psychosom. Medicine*, Vol. VI, 3, 1944.
- (14) Federn, P.: Ego Feeling in Dreams, *Psychoanalytic Quarterly*, 1922, 3, 4.
- (15) William Menninger: Modern Concepts of War Neuroses, *Bulletin of the Menninger Clinic*, Vol. 10, 6, 1946.
- (16) Anna Freud: Das Ich und die Abwehrmechanismen (The ego and its defenses), Vienna, 1936.
- (17) Karl Murdock Bowman: Modern Concept of the Neuroses, *Journal of the A. M. A.*, 132: 555, November 9, 1946.
- (18) Melitta Schmideberg: The Treatment of Psychopaths and Borderline Patients, *American Journal of Psychotherapy*, Vol. I, 1, 1947.
- (19) Heinrich Meng: Praxis der Seelischen Hygiene (Practice of Mental Hygiene), Benno Schwabe & Co., Basle, Switzerland, 1943, and Praeventiv-Hygiene des Verbrechens (Preventive Hygiene of Crime), Benno Schwabe & Co., 1947.
- (20) August Aichhorn: Wayward Youth, The Viking Press, New York, 1935.
- (21) Eric P. Mosse: Painting Analysis in the Treatment of Neuroses, *Psychoanalyt. Review*, 1939.
- (22) Eric P. Mosse: Color Therapy, *Journal of Occupational Therapy & Rehabilitation*, Vol. 21, 1, 1942.
- (23) Harry Benjamin: Eugen Steinach, 1861-1944, A Life of Research, *The Scientific Monthly*, Dec. 1945.
- (24) John N. Rosen: A Method of Resolving Catatonic Excitement, *Psychiatric Quarterly*, Vol. 20, No. 2, 1946.
- (25) Robert M. Lindner: Rebel Without a Cause, Grune & Stratton, New York, 1944.

CONCEALMENT OF FACTS IN PSYCHOANALYSIS

STANLEY KROLL, M.D.

Zurich, Switzerland

As is known, neurosis has its origin in the repression of thoughts to which painful emotions are attached. Accordingly, psychoanalytic treatment aims at the removal of repressions. The patient must become conscious of hidden facts, the perception of which he has up to that time been seeking to avoid. The patient's policy of overlooking a number of his tendencies must yield to a policy of honest understanding.

It is inevitable that the patient should also relive the painful emotions he has repressed together with the tabooed thoughts. The analyst forces him to revive material that has always been troublesome. Against this process the patient rises up in self-defense and it is this defense which we call "analytic resistance."

While the will to be well should make the patient willing to bring into the open even that part of his thinking that is painful to him, his resistance to do so, his defense against mental discomfort connected with such revelations exists and often jeopardizes the success of the treatment.

When the resistance becomes too powerful, when the will to recovery is not strong enough to smooth the way for analytic introspection, then, despite all interpretative work, the analysis must fail. In such cases it is of no avail to assure the patient that the dreaded discomfort of having to face his repressed tendencies will be only ephemeral. Neither will it help to hold out to him the prospect of triumphing over his tabooed emotions, once he has become clearly conscious of them. In hopeless cases of this kind the patient obstinately persists in his defensive mental rigidity. He rejects all beneficial introspection, because it appears to him more unbearable than his illness. If a friendly urging is of no avail and the patient's resistance keeps on congealing, the analyst will then be justified in pronouncing that his patient "does not want" to become well. (It is to be assumed, of course, that the physician has previously recognized and corrected all other facts pertaining to resistance.)

It is sometimes hard to explain to a doubter that a patient may day after day submit to an expensive treatment without actually