A Contribution to the Psychology of Schizophrenia

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In this inquiry into schizophrenia, the focus will be on the internal organization of the personality and on the manifestations of this organization that can be inferred from observations of the "psychotherapeutic" (and other types of human) relationship with the "schizophrenic." Accordingly, this analysis will concentrate on relatively more abstract features of schizophrenia than those associated with the presence or absence of "symptoms" and the allied notion of social adaptation. The latter notion is considered to be particularly distracting, since the very importance of the value judgments inherent in social adaptation and its failures makes it difficult for one to remain uninfluenced by them and to apply one's interest to other facets of the problem. For the sake of clarity, I want to state also that considerations of the phenomenology, genesis, and "symbolic" meaning of psychotic symptoms will also be omitted in this study. The chief theoretical concepts which will be used will be those of object-relationships (i. e., internal and external objects) and the capacity to form and use abstractions (i. e., the differences in the ego's attitude toward concrete objects and abstract symbols).

"Schizophrenia" as Deficiency State in the Adult with Respect to Internal Objects

Psychoanalytic work on the problem of schizophrenia so far has dealt predominantly with the nature and meaning of the symptoms (manifestations) characteristic of this syndrome. The theory of schizophrenic symptom formation provides a good account of the nature of this process.[18,24] Important and valuable as this aspect of the theory of schizophrenia may be, we shall not be concerned with it in this essay. Instead, we shall focus on a more abstract quality of the general psychological organization of persons who, under given circumstances, may or may not manifest psychotic (or other) "symptoms." This point of view, namely, to regard symptoms as the manifestations of a disturbance in a human situation rather than as something "inherent in a disease," is consistent with the psychoanalytic philosophy of the study of human living. Indeed, much of what follows will represent a synthesis based on the work and findings of numerous other investigators.*

Process of Growing Up Viewed in Terms of Object Relationships.—To begin with, let us take a brief glimpse at the psychological process of growing up. This could be described most concisely by stating that it consists of the building up (within the ego, as well as in the process of interaction with it) of large numbers of internal objects. The origin of this notion we owe to Freud and his concept of superego formation. The process which we have in mind, however, is a more general one, and, according to it, the ego itself is composed

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* The psychoanalytic aspects of the theory here put forward were influenced chiefly by the works of the following: Eissler,[11-14] Fairbairn,[25] Kasanin,[39] and Wittels.[79,80] In addition to these, the recent writings of Hoedemaker,[34] Pious,[49,50] and Wexler[75,76] were helpful in organizing the thesis presented in this essay.

of introjected objects.† To ensure healthy development, the objects to be introjected must, first of all, be available; and, secondly, they must be so constituted that they will tend to favor "autonomous" ego development, on the one hand, and be adequate for coping with the complexities of civilized living in a modern industrial society, on the other.

Such a view of psychological growth in terms of the acquisition of "objects" (and, of course, of making them one's own) is, in a way, analogous to physical growth as a process of tissue building. In the latter, the continuous change from infancy to adulthood (and after) represents, from the physicochemical point of view, the taking into the organism of external "tissues" and their assimilation into one's own. Thus way the infant's body grows (literally). In adulthood, literal growth ceases, but a steady process of physicochemical transformation continues. It seems to me that we might well regard the development of the "personality" in a similar manner. While the body feeds on food, the personality "feeds" on objects. It need hardly be added that this is an abstraction, since in human life, as we know it, there is no such thing as the one without the other. The Bible says, "Man does not live by bread alone." This reminder was, and continues to be, necessary because man's interaction with his (nonphysical) "human" environment is less concrete, and therefore more elusive, than is his contact with inanimate bodies.

† In this I follow the ideas of Fairbairn and Wittels. In classical analytic theory the superego is essentially the only (personal) internal object. I believe that the formulation of schizophrenia as a deficiency or defect of the superego, such as was proposed by Pious[60] and others, may stem from an attempt to fit the observations obtained in the therapeutic situation with the schizophrenic into the classical theory. This is undesirable mainly because Freud's original concept of the superego refers to an internal object typical of the "normal-neurotic" adult. The superego is an excellent concept, but its value would be only impaired if it were extended to include the processes of ego building proper.

Returning to the growth process, we could summarize the essential features of it as follows:

1. The acquisition (internalization) of objects
2. The "assimilation" of the objects into the ego (and self)
3. Learning how to relinquish objects and to acquire new ones

All three of these, in various measures, are necessary for the development of the personality in that particular way which we consider "human" in our culture. The synthesis of (adequate) internal objects into a harmonious whole is necessary in adult life for more or less satisfactory living.[80] The disparities between the "realities" of inner (old) and outer (current) objects constitute, in one sense, "neurosis."[37] Viewed in this light, "neurosis" must be regarded as "normal" for adult human living, insofar as the existence of a rich source of inner objects must unavoidably lead to some disparities between these and current human relationships. Optimal psychological "health"—in this frame of reference—consists of the ability to make the necessary discrimination in regard to the foregoing disparity of human object relationships. Without this, the acquisition of new objects is hindered by the presence of older ones. At the same time, our concept of the "ideal" personality demands a measure of stability and permanence in regard to certain objects (e. g., mother-father, wife-husband, etc.).‡

‡ Clearly, what is referred to as the building up of internal objects describes the same phenomenon as what has been known in analytic theory as "identifications" (e. g., the developing child "identifying" himself with mother, father, brother, etc.). If identification is used in this sense, the notion of introjecting external objects and so building up internal ones is synonymous with it. However, the concept of "identification" is also used in another sense, namely, to describe a much more complex and genetically "later" psychological operation, such as occurs when we put ourselves, so to speak, into someone else's position. In this way, we "identify" with him, yet retain our own, preexisting identity. Finally, the fact that the expression "to identify with someone" . . . connotes an active process on the part of the ego—rather than something that hap-

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The "Schizophrenic" and the Child.—It seems to me that most instances of "schizophrenia" are best understood as representing a state of deficiency of (adequate) internal objects in an otherwise adult human organism. This makes for certain basic similarities between the schizophrenic and the child, which have been noted by many authors. However, the differences between the two should not be slighted, lest we make a connection between them not unlike that between a cachectic adult and a child based on the mere fact that both are of the same weight. In other words, while the schizophrenic suffers from a deficit of internal objects, he is physiologically usually mature and his personality organization usually differs in various ways from that of child. Last but not least, the social structure in which the child and the schizophrenic adult live, or are expected to live, differ in exceedingly important ways.

A theoretical approach to schizophrenia in the foregoing terms is advantageous for several reasons. It helps to cut across the accustomed nosological lines. The traditional diagnostic categories of schizophrenia are based on the phenomenology of symptoms (including "affects" and other criteria) and on social judgments. Accordingly, they may be helpful in determining when social action should be taken toward a particular person and when it need not. At the same time, traditional nosology, as is so often emphasized—without, however, anything being done about it—places a tremendous barrier in the way in our attempts to arrive at a scientifically more accurate and socially less biased assessment of certain types of human behavior.

It should be evident that not necessarily all persons "nosologically schizophrenic" will be found to have a (developmentally determined) deficiency of internal objects, although this would probably be true in most cases. On the contrary, the symptomatic concept of schizophrenia is far too narrow as a notion under which all adults relatively poorly endowed (or deficient for other reasons, such as severe regression or organic brain damage) with internal objects could be subsumed. It is not advocated that our view of schizophrenia necessarily be broadened so as to include all these concepts. We merely want to establish some connections between the structure of internal objects and the ego's ability to relate to abstractions (i. e., the power to form and use symbols). Furthermore, this approach will enable us to make significant connections between the nosologically schizophrenic and the socially normal (nonschizophrenic) person.

Evidence in Support of the View of "Schizophrenia" as Deficiency of Internal Objects

A manifest schizophrenic breakdown is usually precipitated either by the loss of an external object or by the need to make a significant relationship with such an object. Let us analyze the nature of these events in some detail. The loss of an object is a general and fundamental sort of "trauma," perhaps comparable to starvation in the physical realm. The healthy adult organism can, of course, withstand the lack of food for a relatively long time. Similarly, object loss is painful but bearable, as a rule. What makes it bearable? The process of mourning is a familiar one and requires no comment. We take for granted, of course, that mourning can occur only in a relatively well-developed personality. A crucial phenomenon in the process is the abandonment of an external object relationship and the (temporary) substitution for it of an internal object relationship (i. e., between the superego and the ego). Mourning is thus made possible by the very existence of a latent inner reservoir of objects

pens as a result of an interaction—makes this concept, expressed in this way, somewhat misleading when we refer to early ego development: The latter cannot be predicated upon the very "system" (ego) which is in the process of creation. According to this formulation, an ego is necessary for "making" identifications, while, at the same time, the ego is being made up (in large part) of "identifications."

upon which the ego can draw in the case of need (much like stored glycogen, fat, and muscle protein as inner sources of food upon which the organism draws during periods of starvation). The occurrence of a schizophrenic break in the face of the loss of an external object might be regarded as evidence of a lack of "stored objects" (if such terms are permitted). As a matter of fact, we are accustomed to interpreting certain types of gregariousness in human relationships as protection on the part of the ego against an inner "emptiness."

Internal Objects and "Fantasy Objects."

I believe we should regard hypochondriacal preoccupations and psychotic delusions and hallucinations in a similar manner: They are "objects" for the ego's interest.[66,71] The ego can function and, so to speak, experience itself vis-a-vis these substitute objects (i. e., the body, "fantasy objects," etc.) and can thus stave off "nothingness" (death, dissolution, aphanisis[36]). It must be noted that what we call "fantasy objects" are by no means the same as internal objects. Internal objects are always historically derived from external objects, and the process of internalization is, accordingly, something that originally happened to the ego in a passive way. "Fantasy objects," on the other hand, are not so derived, but originate from the ego's own defensive, self-reparative struggle and creative effort.§ An inner appreciation of this difference between these two types of "objects" is postulated. "Fantasy objects" are readily given up when (real) external objects become available to the ego. Internal objects, on the other hand, are often never given up at all, or are relinquished only slowly and gradually.

§ Although the term "fantasy object" is newly coined, the observations to which it refers have been described in various ways by others. Rosen, for example, speaks of the "reality of schizophrenic 'imaginations.'"[67] Rycroft, in a recent paper, seems to describe a very similar concept when he speaks of "pathological idealization" as "the result of a defensive hypercathexis of imagos produced by splitting of introjected external object imagos and their later imaginative elaboration."[60]

How Do We Make Inferences About the Ego's Relationship with Objects? "Models," "Transferences," and Affects.—We might digress here and comment briefly on the ways in which we can infer the nature of the ego's relationship to objects. One of the best methods at our disposal lies in observations based upon the patient's response to the psychotherapeutic situation. We thus speak of the immediate and intense "transferences" which the schizophrenic makes to the physician. On the other hand, we know that in the neurotic the development of a transference neurosis toward the analyst is a slow process, which unfolds, with its various ramifications, only gradually as the resistances to it are analyzed. It is somewhat misleading to speak of "transference" in the first case, since it is a significantly different phenomenon from that occurring in the neurotic. In other words, by transference we usually understand the patterning by the ego of a relationship to an external object on the model of a preexisting relationship with an internal object; the latter, in turn, is derived, at least in large part, from a relationship with an external object. It follows that if there is a lack or relative deficiency of internal objects, transferences (in the foregoing sense) cannot occur. This, of course, does not mean that no human relationship can develop, as was Freud's early impression of the "narcissistically isolated" schizophrenic. The relationship which develops in such situations has sometimes been designated as a "real" relationship to the therapist, in contrast to a "transference" relationship. This name is exceedingly ill chosen, inasmuch as it fosters the idea that there is something "unreal" (make-believe, etc.) about the transference. I would suggest that we call this type of ("real") relationship a "model relationship." This name is based on the fact that the object of such a relationship functions for the ego as a model (example) for introjective learning.[19] The prototypes of such relationships would be that of the small child vis-a-vis

his mother, father, and older siblings. Similarly, the schizophrenic's relationship with the therapist is a "model relationship." For a vivid illustration of this phenomenon I shall quote from a paper of Nunberg's, in which he described a phase of a schizophrenic patient's recovery as follows[44]:

> He became interested in the outside world, in political events; he read a great deal, learned other languages, and busied himself in the ward. However, the striking feature was that he wished to work under the direction of a superior, to take orders from him and execute them dutifully. "I will carry out all orders and submit to them completely," he protested. He submitted to my authority, felt helpless and dependent on me, asked for orders and commands from me on how he ought to behave. "You must teach me how to do everything," he told me.

The patient here verbalizes his wish and need for a model upon which to base his ego organization.

For obvious reasons, model relationships are of greater importance during the earlier periods of human life, and transference relationships become more significant as we grow older. Model relationships, however, never cease to play a role, and a certain amount of learning takes place in this way throughout life.

The two types of human relationships designated as "model" and "transference" relationship correspond, it seems to me, to two fundamentally different ways of learning. The first leads to learning by example, or by "identification"; illustrative of this process is the child's learning his mother tongue. In contrast to this, a relationship based on "transference" implies abstraction, comparison, and logical discrimination: It leads to learning by understanding, and the methods of logic (and science). Illustrative of this process is the learning of the scientist. Significantly, this is based on a conceptual chain of events consisting of observation - inference - experiment and/or new observation, etc.; this type of learning does not require the presence of another person as a concrete object. Although in actual life—for example, in school situations—the foregoing two types of learning experience usually occur simultaneously, a clear distinction between these processes would probably be helpful for a better understanding of the psychology of education (cf. Polanyi[51]).

Regarding the concept of "transference," it is clear that model relationships form the bases upon which later transference relationships rest. Yet it is also not altogether incorrect to speak of "transference" in the schizophrenic, for two reasons: 1. He is not completely devoid of internal objects, which are predominantly "bad". 2. In a somewhat wider sense of "transference" we might also speak of the patterning of the ego's relationship to the new model object on the basis of its former relationship with fantasy objects as "transference." This phenomenon seems to be of considerable importance in schizophrenics, and also to a less extent in others more richly endowed with internal objects.

Another important method by which we can make inferences regarding the nature of the ego's relationship with objects lies in observations about the person's emotional (affective) experiences. We are justified in regarding affects, from this point of view, as indicators of whatever the state of affairs between ego and object[29,30,70] happens to be at a particular time. Anxiety thus "means" that the ego feels threatened by impending object loss; mourning signifies that the threatened loss has occurred and is acknowledged by the ego, and pain, for example, indicates a certain kind of relationship between ego and body (as object). Accordingly, the emotional impoverishment or affective "dulling" of the schizophrenic would lead us to conclude that this phenomenon is an indication that there is a deficiency in the number and the range of objects available for interaction with the schizophrenic ego. In other words, (true) lack of affects signifies lack of objects.‖

‖ For a similar view of this phenomenon formulated without using the concept of object relationships, see Arieti. He writes[1] (page 308): "When the patient loses his common symbols and

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Some Connections Between Social Situations and Schizophrenic Symptoms.—It remains for us to comment on the mechanisms by which the need to make external object relationships may precipitate overt schizophrenic symptoms. We conceive of the schizophrenic, when he is in a socially and psychologically relatively well-compensated state, as being able to form relationships with external objects only of the "model" variety. The object suitable for this type of relationship is not too readily available, since it requires a special sort of orientation on its part toward the "schizophrenic." In order to establish a manageable relationship with most people, it is necessary that the adult ego should know how to conduct itself with respect to the object's specific psychological needs and social requirements. This "knowledge" is based on previous human relationships of a more or less similar nature, which serve as models for later relationships. The lack of such internal models (objects) explains the difficulties which arise with the need for human relationships at a later time. By the same token, faced with such a need, the ego is confronted with what appears to it as a task which it is ill equipped to handle. It is in this way that the previously compensated state may give way to an overt psychosis; the latter is the restitutive defense against the ego's confrontation with its lack of (adequate) internal objects and its realization of "inadequacy" in interacting with people. This process may be likened to calling someone's bluff in a poker game.

The onset of symptomatic schizophrenia in early adult life, when the socially grown "child" must leave home and make contact with others, is consistent with the foregoing considerations. Only by deemphasizing symptoms, and their usually catastrophic social consequences, can we pay adequate attention to the nature of human relationships in the life of schizophrenics. The latter tend to be obscured by focusing on precipitating causes, genetic predisposition, or mechanisms, although all of these must be taken into account for a comprehensive picture of "schizophrenia." Finally, we may conclude that not only does individual (e. g., sexual) or social (e. g., choice of occupation, marriage) pressure toward object-contact function as a "stress" pushing the person closer to overt schizophrenia, but, contrariwise, simple and well-structured social situations (e. g., religious orders, military organizations, etc.) tend to protect him from it.

Connection Between Object Relationships and Symbol Formation

To describe and explain psychological phenomena in terms of object relationships is a mode of thought that is becoming increasingly familiar to psychiatrists and psychoanalysts. This material can now be brought into connection with notions about symbol formation, the capacity for abstraction and related ideas. The latter concepts, too, are familiar to many workers in the psychological field. Many of these concepts, however, have been developed by philosophers and have remained relatively isolated from psychoanalytic theory. It is not within the scope of this essay to develop the connections between "objects" and "symbols" in detail. Only those aspects which pertain to our present inquiry into the nature of "schizophrenia" will be considered.

The best criterion for differentiating between man and the higher mammals is the specifically human capacity for abstraction. This capacity finds expression in language, ego formation, organized memory, culture, science, and numerous other manifestations based on symbols.¶ This psychological capacity is made possible by, and has developed in the course of evolution concurrent with, the growth in size and complexity

therefore desocializes himself, it is impossible for him to have any emotional reaction to these common symbols. In other words, he does not repress the emotions; he cannot experience them."

¶ For a comprehensive presentation of this approach to the nature of human experience, see the works of Cassirer,[7,8] Goldstein,[26–28] and Langer.[42,43]

of the frontal, and to a less extent, the temporal lobes of the brain. In other words, we would be justified in saying that what is specifically "human" about man is the development of the frontal lobes, the ego, and the ability to make and use symbols, including those of language. The foregoing statement describes a complex subject from three complementary frames of reference: 1. The frontal lobes refer to anatomical, physiological, and physicochemical matters. 2. The concept "ego" implies the notion of object relationships and constitutes the frame of reference of psychoanalysis. 3. Lastly, the frame of reference of symbolization deals with our subject with the methods and concepts of symbolic logic, semantics, and modern philosophy.[17,54,61]

There is a compelling linkage between object relationships and symbols along the following lines: The behavior of the young child, until the age of the beginning of speech, can be reproduced in most respects by chimpanzees reared like human infants. The life of this presymbolic organism is characterized by an immediacy of all experience. This is often described by saying that for the small child there is no past and no future, but only a present. The abstractions of "past" and "future" and the differentiation between the "possible" and the "real" are not present at this stage of development.[43,46,47]

Further, we can observe a parallelism in the growing child between the development of object relationships and the increasing capacity for abstractions. It seems to me that this is neither simply a fortuitous coincidence nor a mere parallelism of a complex development viewed from different points of view. Rather, it appears that we are dealing with a genuine interdependence of biological functions in such a way that the development of one function facilitates, and is necessary for, the development of the other, and vice versa.

Abstraction; Delay; Long-Circuiting.—How does the capacity for abstraction develop? It is generally assumed that the power to form symbols arises *pari passu* with "psychological development." In other words, this function is thought to develop, like many others, as a part of our genetic (in the physical sense) heritage. Now it seems to me that the evidence strongly suggests that the formation of stable ("good") internal objects is a prerequisite for symbol formation. The "survival" of the ego depends, as has been mentioned, on contact with objects. At first this must be contact with properly supporting external objects. If this and similar contacts are satisfactory, they will be introjected into the ego, and in this way the latter becomes relatively independent of (more or less) continuous contact with external objects. Instead, the ego will be able to tolerate separation and distance from external objects, and it will be buttressed in this ability by its now inviolably intimate and secure contact with internal objects. The very "reality" and security of the ego's relationship with its internal objects makes it possible for it to enter into a more tentative and discriminating contact with external objects. It will thus be able to deal with external objects not only as "immediate objects" but also as abstractions, represented by symbols. The basic symbols which carry and embody the objects which they represent are, of course, pictures (images) and words.

The phenomena which we have described above have been considered by neurologists from the point of view of the evolution of nervous organization, from the simple reflex arc of lower animals to the complex long-circuited central nervous system of man. Accordingly, in the three complementary frames of references mentioned, frontal lobes, ego, and symbols could all be viewed as mechanisms which enable man to transcend the immediacy of his concrete experiences and actions. It is in this fashion that a distancing between experiencing organism (self, ego), on the one hand, and representation (symbol) of experience, on the other, comes about. The frontal lobes, as a colossal synaptic switchboard, form the structural basis for a delay of inpulses (messages in terms of electrical and chemi-

cal events). Similarly, the building up of internal objects in the ego enables the latter to wait—to experience a delay in responding to needs and stimuli. Finally, symbols, too, are regarded as intermediates between concrete objects, on the one hand, and action, on the other; in this instance, representation and abstraction (whether in imagery, thought, etc.) is a measure of "long-circuiting."

Symbolization of Objects and Concrete Use of (What Appear to the Observer as) Symbols.—What evidence justifies the postulate that the formation of adequate internal objects in the early ego is a prerequisite for the development of the capacity for abstract thought? Clearly, the most important information would have to come from observations about the nature of symbol formation in children (or adults) who have been deprived of external objects and are therefore deficient in their ego organization of internal objects. A few children have allegedly grown up under almost totally nonhuman conditions, like jungle animals. According to reports, these children were much like animals and possessed no power of speech.[43] The development of symbols is thus not based simply on an inborn, genetic mechanism, like the proper development of the teeth, tongue, and other "organs" of speech. It depends upon a properly "human" environment.

It was suggested that we look upon "schizophrenia" as a deficiency of internal objects. Observations regarding the ability to form and to use symbols in such persons would thus also serve as an important source of evidence regarding the connection between "internal objects" and symbols. Indeed, we find that schizophrenics manifest significant deviations in regard to language and other symbols as compared with "normal adults." They do not treat (what to the observer are) symbols as abstractions but, rather regard them as concrete, "real" objects.[3] This fact is consistent with our thesis that the presence of internal objects is a requisite for the proper use of symbols on the part of the ego. Beyond this, it illustrates that some symbols (words) may be used in an "imitative" manner, and in this way they can serve the same protective function for the ego as do "fantasy objects." Lastly, such "objects" are made, so to speak, with the help of the nonsymbolic, concrete use of language and imagery (e. g., "delusions").

On a higher developmental level, the interconnections between objects and symbols is more intricate. Not only do internal objects potentiate the acquisition of symbols, but the learning of symbols further facilitates the ego's relationship to new external, and ultimately new internal, objects (experiences). A more detailed examination of this process must be postponed for another occasion. It should suffice to note, at this time, that this process of mutual facilitation appears to be of the greatest importance for the understanding of the (relatively) rapid growth of culture and of science. It also has important bearings on the psychological nature and function of "theory," stemming from the fact that abstract conceptions can function vis-a-vis the ego in a manner similar to internal objects. Both the power of theory for mastering "external reality," as well as the dangers inherent in abstractions as substitutes for concrete objects, derive from this fact.

Analysis of Processes by Which the Schizophrenic Is "Changed" by Major "Therapeutic" Techniques Currently Employed

Efforts to influence the (behavioral) state of schizophrenic patients are usually divided into two large categories, called psychotherapy and physiological therapies. We shall consider them in this order.

The common denominator among the psychotherapeutic approaches lies, obviously, in the fact that the effort to help the patient rests on his being brought into contact with the person of the therapist. The exact ways in which this is "therapeutic" has received a great deal of attention

from psychiatrists and has led to a multitude of "explanations."[4,65] The chief reason for the foregoing situation, it seems to me, is to be found in the close connection between the notions of "psychotherapy" and a logical, verbal exchange between patient and therapist. Redlich,[52] for example, states (page 30):

> However, no generally accepted theory accounts for vast differences of approach in the psychotherapeutic process with schizophrenics, varying from rather different ego-supporting approaches to the direct id-interpretations of Rosen, from vigorous manipulation of the patient to marked passivity of the therapist.

It seems to me that we should consider the possibility that it is not so much the foregoing "treatments" that are different, but, rather, that we have come to describe processes with significant common features in markedly different ways. In other words, I suggest the possibility that it is not the actual operations of the "human relationship" between therapist and schizophrenic patient that vary greatly, but only the ways in which we have become accustomed to describe these therapies. Perhaps we are saying the "same thing" in many different languages—and do not recognize this state of affairs because we mistakenly identify different linguistic forms with different "meanings."

Another serious objection to describing various therapies as "ego-supportive," "uncovering," "active," "passive," etc., lies in that these terms all refer to what the therapist aims to do. Therapy is thus characterized in terms of the therapist's intent, and not in terms of the actual operations which occur in the relationship between patient and therapist.[67] For the latter, the real meaning and impact of the therapist's activity on the patient must be known and taken into account. Only in this way can we avoid the ambiguities that result from the many well-known instances—which hardly need be documented further—in which what seems like "passivity" to the therapist has some very "active" meaning to the patient, or of situations intended to be "ego supporting" having no such effect.#

In psychoanalysis—the model of all modern psychotherapies—it is taken for granted that the patient's "free associations" and the analyst's "interpretations" are of crucial significance in the therapeutic process. And so they are. We must remember, however, that the analytic process proper requires a well-developed ego on the part of the patient, and that it is a process largely based on, and utilizing, abstractions (mostly in the form of linguistic symbols) as a means of establishing contact between two human beings.

It is the utilization of the conceptual framework of abstraction and logic which leads to the apparently paradoxical state of affairs in which we are confronted by a number of different psychotherapies—in the logical content of their assertions each extremely different from the other—yet each of which appears to be helpful (to a point) for the patient. In other words, the questions which we want to answer are the following: How is it possible that the "logically" (and contextually) different approaches of Federn,[16] Fromm-Reichmann,[22] Rosen,[56] Schwing,[62] Sechehaye,[63] and others[5] are all helpful to the schizophrenic? Is one of these approaches more and another less correct? What is the relevance of their logical propositions to the so-called "disease process" at hand? What is the mode of operation of these therapies?

Object Contact with the Schizophrenic.—The idea that what is relevant in the therapeutic contact between the schizophrenic and his therapist is somehow the object relationship itself, and not the "verbal communication," is by no means novel. Indeed, this is sometimes claimed for the "analytic situation," too, and in this way the entire theory of psychotherapy becomes muddied and confusing. A clarification of what is meant by the therapeutic effect of the "relationship itself" is badly needed.

See in this connection Szasz and Hollender.[72]

The notion of "nonverbal communication" with the schizophrenic also refers to what I am discussing here. An unfortunate dichotomy often arises, in this connection, between verbal and nonverbal communication, so that the latter becomes equated with that which has an "emotional" impact on the patient, and the former with that which has a merely "intellectual" effect. The juxtaposition of these concepts and modes of experiencing is grossly misleading. As I see it, in the presymbolic state (e. g., a small child), living in concrete action and its inner representation predominantly by "feelings" constitutes both the emotional and the intellectual aspect of the organism's experiences. Similarly, for the adult for whom symbols are meaningful, verbal language is not an intellectual expression only, but is equally as much an expression of emotion. The words "emotional" and "intellectual" serve us best as a means of subdividing experience. These terms are often used, but should not be, as denoting levels of organization, with the implication that "emotionality" is more primitive and "intellectualism" more mature. It is in this way that the myth that the mature adult is less emotional than the child arose. It would seem more consistent with the facts not to speak of emotionality as "more or less"—as if it were a matter of quantity—but, rather, to try to comprehend the different ways in which organisms of diverse organization experience emotions.[12,43] The adult is, accordingly, not less emotional than the child, but is emotional in a different way; and, as a matter of fact, if we think of emotions not in terms of whether they overcome us, or not, but in terms of their range, (i. e., variety, subtlety, complexity), then we realize that the adult would have to be regarded as more, and not less, emotional than the child.

We have suggested that the schizophrenic is deficient in internal objects, whereas the "neurotic" is not. The need arising from this is one for external objects suitable for introjection. This would constitute the natural reparative tendency of the organism. It is important to note that people with whom the schizophrenic comes into contact in the course of "normal" social intercourse are not available as objects for the type of interaction which he requires. I would compare this situation with the psychology of child-raising. Most people like children, in a vague and general way, but would not be interested in raising a strange child just because the child needs a parent. Adults seek most of their human contacts on "another level." In any case, there must be a reciprocal need in the adult toward the child in order for it to function as a parent. Generally this is not a problem, since this reciprocity of needs flows directly from the adult's need to take care of himself, which is readily displaced onto his own child.* Similarly, to treat the schizophrenic, the therapist must have a need of his own to make contact with, and to devote himself to, the patient.[13] This reciprocity of needs, and this alone, would make the therapist available to the patient as an object for introjection. However, this in itself is not enough. I would add to this, that the therapist must show the patient by example how he himself deals with the world (this includes his own impulses, as well as his orientations and techniques of relating to other people and inanimate objects). In this way the patient gains access to that prototypal experience from which he was deprived in childhood, namely, to learn how to deal with the world by introjecting adequate objects. This process is often called simply "love." Unfortunately, this one word is used as an abstraction of so many

* I ask the reader's indulgence of this and other similar oversimplifications. In a study of a problem which is as poorly circumscribed as schizophrenia is today, one cannot help touching on numerous issues subsidiary to the one or few themes which can be developed in a short paper. Faced with such a problem, one might disregard subsidiary issues altogether, digress into more or less detailed discussions of them, or aim at some compromise between the two extremes. I have chosen the last course, in most instances, thinking that a brief statement of my position regarding the issue in question would mislead the reader the least.

diverse experiences that an explicit analysis of its meaning in discrete contexts is a necessity for work which aims at scientific, rather than sentimental, appeal.

Communications with the Schizophrenic Are Not in Form of Logical Propositions.

The foregoing conceptions have far-reaching implications for the problem of the logical diversity of various psychotherapies used with schizophrenics. As we have noted, not only is the schizophrenic deficient of internal objects, but he is also unable to use abstractions (symbols).† It follows, therefore, that what may have various abstract meanings to us, as psychiatric observers, may have no such meaning to the patient. The fact that the patient "listens" to what is said to him, that he appears to accept it and even may make the interpretations his own, has no bearing on what we consider, in other situations, as the validity of logical propositions.

It is important to note, in this connection, that the ability to deal with "logical propositions" (in the sense of symbolic logic[54]) does not normally develop until some time after the 11th or 12th year of life. Piaget describes four stages in the "psychological development of operations," the final stage being that of "propositional or formal operations." He states[45] (page 18):

> The final period of operational development begins at about 11 to 12, reaches equilibrium at about 14 to 15 and so leads on to adult logic. The new feature marking the appearance of this fourth stage is the ability to reason by hypothesis. In verbal thinking, such hypothetico-deductive reasoning is characterized, *inter alia*, by the possibility of accepting any sort of data as purely hypothetical, and reasoning correctly from them.

If we agree that in the interaction between therapist and "schizophrenic" patient we are not dealing with logical propositions, the notions of "true and false" or "exact and inexact" cease to be relevant.[25] These concepts are applicable only to certain types of abstractions, namely, to logical propositions. They have no meaning in connection with esthetic or ethical judgments, as well as in many other contexts.[59]

The significance of these considerations for psychoanalytic theory can hardly be exaggerated. Indeed, quite early in his work Freud enunciated what is basically the same principle when he called attention to the absence of (this type of) logic in dreams. For example, two opposite propositions in a dream do not negate one another. Yet, even though these facts have long been known to psychoanalysts, there is a persistent tendency to use adultomorphic, logical considerations in trying to decide, for example, between which of various utterances "said" to schizophrenic patients are "correct" and which are "incorrect." (This is not to say that all "approaches" to the schizophrenic are equally valid and of the same benefit to the patient.) This difficulty may derive, in part, from the fact that science, by definition, is limited to the use of the logical method.‡

† An unfortunately misleading use of the notion of "symbol" has arisen in the psychiatric literature on schizophrenia. I am referring to the commonly held view that the schizophrenic "knows" symbols especially well, that he "understands the unconscious," and so forth. This is based, largely, on a mixing up of the positions and frames of reference of the patient and of the psychiatric observer. In other words, it is one thing to represent an event A by a symbol B—knowing, if necessary, that B merely stands for A—and it is an altogether different thing to equate the two. Thus, when the schizophrenic uses "symbols," he uses them in the second sense only; for example, he may regard an apple as a breast or experience the therapist as his father. Accordingly, when Sechehaye,[68] speaks of "symbolic realization," the terminology conflicts with the concept of symbol as abstraction. And it is evident in her account that the gratifications of the patient's wishes were symbolic only in the sense of their meaning for analytic theory, i.e., for the psychiatrist, but they were not symbolic for the patient. Sechehaye's therapeutic contact with the patient was characterized by prolonged contact of an immediate and "concrete" sort, such as is the rule between mother and child.

‡ We touch here on a matter which is similar in many respects to the problem of "values" and ethical judgments. Considering the relationship between science and ethics, Bertrand Russell wrote as follows[59] (page 255): "I conclude that, while it is true that science cannot decide questions of

(Footnote continued on following page)

I do not want to create the impression, however, that we cannot arrive at an understanding of "schizophrenia" or of the nature of human relationships with such patients by the methods of science. The considerations mentioned above may, however, well account for the significant fact that artists have for so long been more successful in "explaining" the psychology of the child and of the "mentally ill" than have scientists. It seems to me, rather, that scientific effort must not become fixated, so to speak, on the utterances of the therapist or of the patient (patterned after the model of the "analytic situation") but must abstract certain recurrent patterns and features from interaction with persons in this prelogical state and must then establish laws pertaining to them.

Therapeutic "Experience" Versus Theories of Therapy.—Let us apply what has been said to the concrete example of the controversy regarding various therapeutic "techniques" used with schizophrenics. Psychiatrists argue, reason, and try to decide whether Rosen's highly dramatic and aggressively verbal approach is "correct" or not, or what parts of it might be "right" and what others "wrong." His method may be contrasted with Schwing's quiet, almost silent, contact with her patients.[65] In our efforts to understand how these "mental healers" work, and what effect they have on the objects of their interest, we should compare their work to that of the artist. No one today would waste any time trying to decide whether Rembrandt's or Picasso's "method of painting" is the "correct" one.

In scientific work, "truth" is a matter of degree. In the words of Russell, again[59] (pp. 11, 12):

> Science thus encourages the abandonment of the search for absolute truth, and the substitution of what may be called "technical truth," which belongs to any theory that can be successfully employed in inventions or in predicting the future. "Technical" truth is a matter of degree: a theory from which more successful inventions and predictions spring is truer than one which gives rise to fewer. "Knowledge" ceases to be a mental mirror of the universe, and becomes merely a practical tool in the manipulation of matter.

Russell was speaking, of course, of the physical sciences; similar considerations, however, apply to the psychological sciences as well.

Let us recapitulate the chief conclusion which follows from what was said above. Insofar as we consider the problem of the relationship between therapist and schizophrenic patient from the point of view of science, we must distinguish sharply between the following two categories of events:

1. Individually specific and unique happenings take place between a particular therapist and a particular patient. The communications which pass between these two persons are, for the large part, not logical propositions.[6]§ Accordingly, the methods of science cannot be applied to the "raw material" of the therapeutic situation.

2. We can abstract certain relatively invariant features from the situation under consideration and can thus construct various theories of the process of interaction (and of the "make-up" of the individual participants themselves). From this point of view, a particular therapeutic situation will have to be looked upon as an illustrative example of a more general scheme. In our theory, for example, we have the important invariant notion that the therapist must function as an object available for introjection by the object-deficient patient. Certain "predictions" are inherent in this concept; that is, the therapist's personality will make a strong imprint on that of the patient, so that the latter will become, in

value, that is because they cannot be intellectually decided at all, and lie outside the realm of truth and falsehood. Whatever knowledge is attainable, must be attained by scientific methods; and what science cannot discover, mankind cannot know."

§ Eissler was among the first to bring real theoretical clarity to this issue. He stated that in order to treat the schizophrenic effectively, the therapist must be able to communicate with him in the language of the "primary process."[13] This, of course, is in sharp contrast to the nature of "interpretations" used in the "primary model technique" of analysis.[14,68]

some ways, like the former. This process is, of course, similar to what happens in the course of "normal" childhood development, in that the child becomes, in part, an embodiment of those who raise him. The differences between the theory of the treatment of schizophrenics, on the one hand, and the theory of "psychoanalytic treatment," on the other, are most evident in this connection.[68,69]

We may now conclude that the differences among diverse psychotherapeutic approaches to the schizophrenic lie (chiefly) in differences in the logic of the propositions by which the therapists involved explain their procedures to themselves and to their colleagues. This does not interest the patient. The analogy with child-raising is again helpful. There are numerous diverse explanations as to why parents and educators do whatever they do with children. "In spite" of these logical differences, children manage to grow up, insofar as there are adults who genuinely "take care" of them. Furthermore, the diverse "communications," so to speak, with which schizophrenics are treated could be well compared with the child's response to being talked to or read to. We know how much children love both to be talked to or to be read to, but we know better than to attribute this to their interest in the particular narrative at hand. The French say, *C'est le ton qui fait le music.* In other words, the small child will "respond" almost equally to being read to from a children's book, a cookbook, or a collection of Shakespeare's sonnets, as long as this is done with interest on the part of the adult. Similarly, the diversity of psychotherapeutic techniques with schizophrenics is instructive not on account of any relevance of their respective logical propositions (with regard to the schizophrenic's "conflicts") but as expressions of the individually unique ways in which different therapists experience and communicate their interest in their patients. Some mothers sing to their children; some read to them, and others take them for walks. It would be patently meaningless to inquire as to which of these ways is the best one for relating to the child at that particular time. If there is a genuine relatedness—so that the child or the schizophrenic can learn by introjective identification—any one of these experiences will be valuable for the development of (probably both) the participants. How valuable such differing experiences might be cannot be rationally answered without specifying later conditions under which the person will have to live.

Some Differences Between "Therapy by Example" and "Primary Model Technique."—In summing up these considerations regarding the mode of action of certain types of object relationships with respect to the schizophrenic, a few comments about the differences between the foregoing human situations and the analysis relationship proper might be added. The similarities between the two are essentially limited to the fact that both are "human relationships." The differences seem to me far greater than the similarities, albeit these have been obscured[21] by the fact that verbal communication appears to play a role in both. The treatment of the schizophrenic revolves about remedying a lack of internal objects. Internalizations of the therapist (of his various skills, attitudes, etc.) and of others, insofar as they supply useful models for living, are encouraged. Processes which hinder such introjections are avoided (e. g., analysis of the "imitative" processes). If therapy is successful, the patient may gradually reach a stage of human existence comparable to that of the adult "normal-neurotic," who may or may not be a candidate for analysis. The "primary model technique" presupposes a capacity for abstraction in the patient. He is not in need of new internal objects. On the contrary, his relationships with external objects may cause him "pain" insofar as they are insufficiently discriminated from relationships with internal objects. The analytic process uses many symbolic operations, and a (personal) distance from the analyst is maintained throughout the treatment which is very different from the prox-

imity between therapist and patient necessary for the schizophrenic. The memories and constructions of the analysand, as well as the interpretations of the analyst, constitute, at least in large part, logical propositions. The concepts of "exact-inexact" apply to these, as do other criteria of science. The scientific method as such is thus applicable to the contents of the analytic situation. In contrast to this, science can tell us something about the process of interaction between therapist and schizophrenic, but it has nothing to say about the "content" of the interaction. This material is akin, in this respect, to art, ethics, and other aspects of human experience, regarding the content of which science has nothing to say.

Physical "Therapies" in Schizophrenia.—From the foregoing point of view, the mode of action of so-called physiological "therapies" to which schizophrenics are subjected may be summarized briefly as follows: We conceive of the symptoms of "schizophrenia" as restitutive manifestations which attempt to cover up a deficiency of internal objects. Substitutive "internal objects," which we called "fantasy objects," are thus created by the ego. This is made possible for the ego on the basis of whatever sources ("bad," or inadequate) of internal objects it has available. Bodily feelings supply a most important source of "objects" for the object-deficient ego of the schizophrenic, and this accounts for the frequency of so-called hypochondriacal preoccupations in these persons. The somatic and personal "fantasy objects," once manifest, clash with the "objective" universe of the social norm and mobilize action toward, or oftener against, the patient. Rarely, this leads to psychotherapeutic efforts. More frequently, social action leads simply to the removal and incarceration of the manifestly offending ("offensive") individual.

The physiological methods which may now be invoked, while again varied in specific technical details, share the common denominator of being destructive of the higher centers of the brain. Accordingly, the modes of action of the various shock therapies, of lobotomy, and of other destructive operations on the brain could all be said to center on interfering with the physiological function of the frontal, and to a less extent the temporal, lobe. These parts of the central nervous system are necessary for abstract thought and creative effort. They subserve the ego's growth in progressive introjections of objects and the development of the power to form and to use symbols. Similarly, they are also necessary for the compensatory effort of building up and "energizing" "fantasy objects." Destruction of parts of the brain subserving this function will, accordingly, eliminate the "symptoms" of schizophrenia insofar as these are seen in the patient's creation of "fantasy objects." Indeed, these procedures may reduce the patient to a state where he will live devoid of internal and external objects, and at the same time he might remain unoffensive in his demands upon society. The physiological treatments of schizophrenia appear quite analogous to the early medical approaches to the diabetic, who was deprived of carbohydrates and often starved of all food: By sufficiently reducing the degree of "aliveness" of the organism, we may delude ourselves into thinking that it is more "normal."

In conclusion, it may be worth while to recall the familiar fact that our concept of "health" will follow generally from our concept of "disease." If we consider schizophrenia to consist of the symptoms which society considers offensive—and this is the basis of our traditional nosology—then removal of the symptoms (irrespective of the method) will be considered "treatment." On the other hand, if we consider the deficiency of internal objects and the inability to deal with symbols as the more crucial phenomenon, then our ideas regarding diagnosis, therapy, and improvement will vary accordingly from traditional psychiatric nosology and will differ from those which advocate physical treatments for schizophrenia. The apparent paradox of

the "therapeutic" use of destroying the highest centers of the brain—which subserve the very functions that are least developed in most people (not only from a "scientific" but also simply from an evolutionary point of view)—becomes understandable by a clearheaded and explicit emphasis on our notions of "pathology."

Summary

The aim of this essay is to attempt a synthesis of psychoanalytic contributions to "schizophrenia" with certain concepts and theories of nonanalytic psychologists and philosophers bearing on the nature and function of the human use of symbols. It is suggested that there is a fundamental interdependence between the development of object relationships and of internal objects, on the one hand, and the adult ability to conceive abstractions and use symbols, on the other.

A formulation of the concept of "schizophrenia" unburdened by the medical model of "disease" and independent of whether its classic symptoms are manifest or not, is put forward. "Schizophrenia" is viewed as a particular mode of psychological organization whose most distinguishing feature lies in the schizophrenic ego's relationship to objects (people) and to symbols. The chief thesis of the essay lies in considering "schizophrenia" as a state of (relative) deficiency of internal objects in the adult. (This is not a primarily etiologically, or genetically, oriented hypothesis.) It is a corollary of this thesis that, in the "schizophrenic," symbol formation is impeded and objects which appear as symbols to the observer might be used in a concrete (nonsymbolic) manner. Further, the "schizophrenic" is needful of, and adapted for, certain types of human relationships which we designate as "model relationships." Society provides ample acceptable ("normal") opportunities for such relationships, as it does also for others. The term "schizophrenia," therefore, as used in this essay, is in no way synonymous with "illness," nor does it even provide a clue for the determination of whether a person is "healthy" or "disabled."

In conclusion, some implications of this thesis for the nature of various psychological and somatic "therapies" of schizophrenia are briefly discussed.

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