NOTES ON THE THEORY OF SCHIZOPHRENIA[1]

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A. Introduction

In this paper I shall discuss the schizophrenic patient's use of language and the bearing of this on the theory and practice of his analysis. At a later date I shall acknowledge my indebtedness to, and discuss the views of, the psycho-analysts who have contributed to the growth of my own views. I cannot do that now, but I must make it clear for the better understanding of what I say that, even where I do not make specific acknowledgement of the fact, Melanie Klein's work occupies a central position in my view of the psycho-analytic theory of schizophrenia. I assume that the explanation of terms such as 'projective identification' and the 'paranoid' and 'depressive positions' is known through her work.

By approaching the subject through consideration of verbal thought I run the risk of appearing to neglect the nature of the schizophrenic's object relations. I must therefore emphasize now that I think that the peculiarity of the schizophrenic's object relations is the outstanding feature of schizophrenia. The importance of the points that I wish to make lies in their capacity to illuminate the nature of this object relationship of which they are a subordinate function.

The material is derived from the analysis of six patients; two were drug addicts, one an obsessional anxiety state with schizoid features, and the remaining three schizophrenics all of whom suffered from hallucinations which were well in evidence over a period of between four and five years of analysis. Of these three, two showed marked paranoid features and one depression.

I did not depart from the psycho-analytic procedure I usually employ with neurotics, being careful always to take up both positive and negative aspects of the transference.

B. Nature of the Observation on which Interpretations are Based

Evidence for interpretations has to be sought in the counter-transference and in the actions and free associations of the patient. Counter-transference has to play an important part in analysis of the schizophrenic, but I do not propose to discuss this to-day. I shall therefore pass on to the patient's free associations.

C. Schizophrenic Language

Language is employed by the schizophrenic in three ways; as a mode of action, as a method of communication, and as a mode of thought. He will show a preference for action on occasions when other patients would realize that what was required was thought; thus, he will want to go over to a piano to take out the movement to understand why someone is playing the piano. Reciprocally, if he has a problem the solution of which depends on action, as when, being in one place, he should be in another, he will resort to thought—omnipotent thought—as his mode of transport.

At the moment I want to consider only his use of it as a mode of action in the service either of splitting the object or projective identification. It will be noted that this is but one aspect of schizophrenic object relations in which he is either splitting or getting in and out of his objects.

The first of these uses is in the service of projective identification. In this the patient uses words as things or as split-off parts of himself which he pushes forcibly into the analyst. Typical of the consequences of this behaviour is the experience of a patient who felt he got inside me at the beginning of each session and had to be extricated at the end of it.

Language is again employed as a mode of action for the splitting of his object. This obtrudes when the analyst becomes identified with internal persecutors, but it is employed at other times too. Here are two examples of this use of language: The patient comes into the room, shakes me warmly by the hand, and looking piercingly into my eyes says, 'I think the sessions are not for a long while but stop me ever going out.' I know from previous experience that this patient has a grievance that the

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sessions are too few and that they interfere with his free time. He intended to split me by making me give two opposite interpretations at once, and this was shown by his next association when he said, ' How does the lift know what to do when I press two buttons at once? '

My second example has wide implications, which I cannot take up here, because of their bearing on insomnia. The technique depends on the combination of two incompatible elements thus: the patient speaks in a drowsy manner calculated to put the analyst to sleep. At the same time he stimulates the analyst's curiosity. The intention is again to split the analyst, who is not allowed to go to sleep and is not allowed to keep awake.

You will note a third example of splitting later on when I describe a patient splitting the analyst's speech itself.

To turn now to the schizophrenic's difficulties with language as a mode of thought. Here is a sequence of associations all in one session, but separated from each other by intervals of four or five minutes.

I have a problem I am trying to work out.

As a child I never had phantasies.

I knew they weren't facts so I stopped them.

I don't dream nowadays.

Then after a pause he went on in a bewildered voice, ' I don't know what to do now.' I said, ' About a year ago you told me you were no good at thinking. Just now you said you were working out a problem—obviously something you were thinking about.'

Patient. ' Yes.' *Analyst.* ' But you went on with the thought that you had no phantasies in childhood; and then that you had no dreams; you then said that you did not know what to do. It must mean that without phantasies and without dreams you have not the means with which to think out your problem.' The patient agreed, and began to talk with marked freedom and coherence. The reference to the inhibition of phantasy as a severe disability hindering development supports Melanie Klein's observations in her paper ' A Contribution to the Theory of Intellectual Inhibition '.

The severe splitting in the schizophrenic makes it difficult for him to achieve the use of symbols and subsequently of substantives and verbs. It is necessary to demonstrate these difficulties to him as they arise; of this I shall shortly give an example. The capacity to form symbols is dependent on:

(1) The ability to grasp whole objects.

(2) The abandonment of the paranoid-schizoid position with its attendant splitting.

(3) The bringing together of splits and the ushering in of the depressive position.

Since verbal thought depends on the ability to integrate, it is not surprising to find that its emergence is intimately associated with the depressive position which, as Melanie Klein has pointed out, is a phase of active synthesis and integration. Verbal thought sharpens awareness of psychic reality and therefore of the depression which is linked with destruction and loss of good objects. The presence of internal persecutors, as another aspect of psychic reality, is similarly unconsciously more recognized. The patient feels that the association between the depressive position and verbal thought is one of cause and effect—itself a belief based on his capacity to integrate—and this adds one more to the many causes of his hatred, already well in evidence, of analysis, which is after all a treatment which employs verbal thought in the solution of mental problems.

The patient at this stage becomes frightened of the analyst, even though he may concede that he feels better, but, and this is where the kernel of our problem lies, he shows every sign of being anxious to have nothing whatever to do with his embryonic capacity for verbal thought. That is felt to be better left to the analyst; or, as I think it more correct to say, the analyst is felt to be better able than he to harbour it within himself without disaster. The patient seems, despite all the work done, to have reverted to the use of language that I have described as characteristic of the schizophrenic before analysis. He has greater verbal capacity but prefers to employ it as he did when it was slight.

D. Development of Capacity for Verbal Thought

To explain why the patient is so chary of using his increased capacity I must report an experience which seems to have peculiar significance for him. A patient said to me, ' I am a prisoner of psycho-analysis '; later in the session he added, ' I can't escape '. Some months later he said, ' I can't get out of my state of mind '. A mass of material, to which quotation cannot do justice, had accumulated over a period of three years to give the impression that the patient felt unable to escape from a prison which seemed sometimes to be me, sometimes psycho-analysis and sometimes his state of mind which is a constant struggle with his own internal objects. He thus shows the same attitude to

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verbal thought as he has to his potency and his equipment for work and love.

The problem to which I am addressing myself can best be understood if it is seen to appertain to the moment when the patient feels he has effected his escape. The escape appears to contribute to the patient's feeling which he occasionally reports, that he is better; but it has cost him dear. This same patient said, ' I have lost my words ', and meant by this, as further analysis disclosed, that the instrument with which he had effected his escape had been lost in the process. Words, the capacity for verbal thought, the one essential for further progress, have gone. On expansion it appears that he thinks he has reached this pass as a penalty for forging this instrument of verbal thought and using it to escape from his former state of mind; hence the unwillingness I described to use his greater verbal capacity except as a mode of action.

Here now is the example I promised you when I was speaking of the difficulty that schizophrenic splitting caused in the formation of symbols and the development of verbal thought. The patient was a schizophrenic who had been in analysis five years; I describe some essentials of two sessions. I must warn you that compression has compelled me to leave out many repetitive formulations which in fact would mitigate the baldness of the interpretations as I report them here. I think interpretation should be in language that is simple, exact and mature.

Patient. I picked a tiny piece of skin from my face and feel quite empty.

Analyst. The tiny piece of skin is your penis, which you have torn out, and all your insides have come with it.

Patient. I do not understand . . . penis . . . only syllables.

Analyst. You have split my word ' penis ' into syllables and it now has no meaning.

Patient. I don't know what it means, but I want to say, ' If I can't spell I cannot think '.

Analyst. The syllables have now been split into letters; you cannot spell—that is to say you cannot put the letters together again to make words. So now you cannot think.

The patient started the next day's session with disjointed associations and complained that he could not think. I reminded him of the session I have described, whereupon he resumed correct speech; thus:

Patient. I cannot find any interesting food.

Analyst. You feel it has all been eaten up.

Patient. I do not feel able to buy any new clothes and my socks are a mass of holes.

Analyst. By picking out the tiny piece of skin yesterday you injured yourself so badly you cannot even buy clothes; you are empty and have nothing to buy them with.

Patient. Although they are full of holes they constrict my foot.

Analyst. Not only did you tear out your own penis but also mine. So to-day there is no interesting food—only a hole, a sock. But even this sock is made of a mass of holes, all of which you made and which have joined together to constrict, or swallow and injure, your foot.

This and subsequent sessions confirmed that he felt he had eaten the penis and that therefore there was no interesting food left, only a hole. But this hole was now so persecutory that he had to split it up. As a result of the splitting the hole became a mass of holes which all came together in a persecutory way to constrict his foot.

This patient's picking habits had been worked over for some three years. At first he had been occupied only with blackheads, and I shall quote from Freud's description of three cases, one observed by himself, one by Dr. Tausk and one by R. Reitler, which have a resemblance to my patient. They are taken from his paper on ' The Unconscious ' (1915).

Of his patient Freud said, he ' has let himself withdraw from all the interests of life on account of the unhealthy condition of the skin of his face. He declares that he has blackheads and that there are deep holes in his face which everyone notices '. Freud says he was working out his castration complex on his skin and that he began to think there was a deep cavity wherever he had got rid of a blackhead. He continues: ' The cavity which then appears in consequence of his guilty act is the female genital, i.e. stands for the fulfilment of the threat of castration (or the phantasy representing it) called forth by onanism '. Freud compares such substitute-formations with those of the hysteric, saying, ' A tiny little hole such as a pore of the skin will hardly be used by an hysteric as a symbol for the vagina, which otherwise he will compare with every imaginable object capable of enclosing a space. Besides we should think that the multiplicity of these little cavities would prevent him from using them as a substitute for the female genital '.

Of Tausk's case he says, ' in pulling on his stockings he was disturbed by the idea that he must draw apart the knitted stitches, i.e. the

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holes, and every hole was for him a symbol of the female genital aperture '.

Quoting Reitler's case he says the patient ' found the explanation that his foot symbolized the penis; putting on the stocking stood for an onanistic act '.

I shall now return to my patient at a session ten days later. A tear welled from his eye and he said with a mixture of despair and reproach, ' Tears come from my ears now '.

This kind of association had by now become familiar to me, so I was aware that I had been set a problem in interpretation. But by this time the patient, who had been in analysis some six years, was capable of a fair degree of identification with the analyst and I had his help. I shall not attempt a description of the stages by which the conclusions I put before you were reached. The steps were laborious and slow even though we had the evidence of six years' analysis on which to draw.

It appeared that he was deploring a blunder that seemed to bear out his suspicion that his capacity for verbal communication was impaired. It seemed that his sentence was but another instance of an inability to put words together properly.

After this had been discussed it was seen that tears were very bad things, that he felt much the same about tears which came from his ears as he did about sweat that came from the holes in his skin when he had, as he supposed, removed blackheads or other such objects from the skin. His feeling about tears from his ears was seen to be similar to his feeling about the urine that came from the hole that was left in a person when his penis had been torn out; the bad urine still came.

When he told me that he couldn't listen very well I took advantage of his remark to remind him that in any case we needed to know why his mind was full of such thoughts at the present juncture, and I suggested that probably his hearing was felt to be defective because my words were being drowned by the tears that poured from his ears.

When it emerged that he couldn't talk very well either I suggested that it was because he felt his tongue had been torn out and he had been left only with an ear.

This was followed by what seemed to be a completely chaotic series of words and noises. I interpreted that now he felt he had a tongue but it was really just as bad as his ear—it just poured out a flow of destroyed language. In short it appeared that despite his wishes and mine we could not, or he felt we could not, communicate. I suggested that he felt he had a very bad and hostile object inside him which was treating our verbal intercourse to much the same kind of destructive attack which he had once felt he had launched against parental intercourse whether sexual or verbal.

At first he seemed to feel most keenly the defects in his capacity for communication or thought, and there was a great deal of play with the pronunciation of tears (*teers* or *tares*) the emphasis being mostly on the inability to bring together the objects, words, or word pronunciation, except cruelly. But at one point he seemed to become aware that his association had been the starting-point for much discussion. Then, ' Lots of people ' he murmured. On working this out in turn it appeared that he had swung away from the idea that his verbal capacity was being irretrievably destroyed by the attacks to which our conversation was being subjected, to the idea that his verbal communication was extremely greedy. This greed was ministered to by his splitting himself into so many people that he could be in many different places at once to hear the many different interpretations which I, also split into ' lots of people ', was now able to give simultaneously instead of one by one. His greed, and the attacks on verbal communication by the internal persecutors, were therefore related to each other.

Clearly this patient felt that splitting had destroyed his ability to think. This was the more serious for him because he no longer felt that action provided a solution for the kind of problem with which he was struggling. This state is equated by the patient with ' insanity '.

The patient believes he has lost his capacity for verbal thought because he has left it behind inside his former state of mind, or inside the analyst, or inside psycho-analysis. He also believes that his capacity for verbal thought has been removed from him by the analyst who is now a frightening person. Both beliefs give rise to characteristic anxieties. The belief that he has left it behind has, as we have seen, helped to make the patient feel he is insane. He thinks that he will never be able to progress unless he goes back, as it were, into his former state of mind in order to fetch it. This he dare not do because he dreads his former state of mind and fears that he would once more be imprisoned in it. The belief that the analyst has removed his capacity for verbal thought makes the patient

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afraid of employing his new-found capacity for verbal thought, lest it should arouse the hatred of the analyst and cause him to repeat the attack.

From the patient's point of view the achievement of verbal thought has been a most unhappy event. Verbal thought is so interwoven with catastrophe and the painful emotion of depression that the patient, resorting to projective identification, splits it off and pushes it into the analyst. The results are again unhappy for the patient; lack of this capacity is now felt by him to be the same thing as being insane. On the other hand, reassumption of this capacity seems to him to be inseparable from depression and awareness, on a reality level this time, that he is ' insane '. This fact tends to give reality to the patient's phantasies of the catastrophic results that would accrue were he to risk re-introjection of his capacity for verbal thought.

It must not be supposed that the patient leaves his problems untouched during this phase. He will occasionally give the analyst concrete and precise information about them. The analyst's problem is the patient's dread, now quite manifest, of attempting a psycho-analytic understanding of what they mean for him, partly because the patient now understands that psycho-analysis demands from him that very verbal thought which he dreads.

So far I have dealt with the problem of communication between analyst and schizophrenic patient. I shall now consider the experience the patient has when he lives through the process of achieving sufficient mastery of language to emerge from the ' prison of psycho-analysis ', or state of mind in which he previously felt himself to be hopelessly enclosed. The patient is apparently unaware of any existence outside the consulting room; there is no report of any external activity. There is merely an existence away from the analyst of which nothing is known except that he is ' all right ' or ' better ' and a relationship with the analyst which the patient says is bad. The intervals between sessions are admitted and feared. He complains that he is insane, expresses his fear of hallucination and delusion, and is extremely cautious in his behaviour lest he should become insane.

The living through of the emotions belonging to this phase leads to a shift towards higher valuation of the external object at the expense of the hallucinated internal object. This depends on the analysis of the patient's hallucinations and his insistence on allotting to real objects a subordinate role. If this has been done the analyst sees before him the ego and more normal object relations in process of development. I am assuming that there has been an adequate working through of the processes of splitting and the underlying persecutory anxiety as well as of reintegration. Herbert Rosenfeld has described some of the dangers of this phase. My experiences confirm his findings. I have observed the progress from multiple splits to four and from four to two and the great anxiety as integration proceeds with the tendency to revert to violent disintegration. This is due to intolerance of the depressive position, internal persecutors, and verbal thought. If splitting has been adequately worked through the tendency to split the object and the ego at the same time is kept within bounds. Each session is then a step in ego development.

E. Realization of Insanity

One of the penalties of attempting to clarify the complex phenomena of the schizophrenic patient's relationship with his objects is that if the attempt is successful it is delusively misleading. I would now redress the balance by approaching the phenomena I have already described from a rather different angle. I wish to take up the story at the point at which the splits are brought together, the patient escapes from his state of mind and the depressive position is ushered in. In particular I wish to draw attention to this concatenation of events when it is suffused by the illumination achieved through the development of a capacity for verbal thought. I have made it clear that this is a most important turning-point in the whole analysis. You may therefore have formed the impression that at this point the analysis enters into calm waters. It is necessary therefore that I should leave you with no illusions about this.

What takes place, if the analyst has been reasonably successful, is a realization by the patient of psychic reality; he realizes that he has hallucinations and delusions, may feel unable to take food, and have difficulty with sleep. The patient will direct powerful feelings of hatred towards the analyst. He will state categorically that he is insane and will express with intense conviction and hatred that it is the analyst who has driven him to this pass. The analyst ought to expect concern for the patient's welfare to drive the family to intervene and he must be prepared to explain an alarming situation to them. He should strive to keep at bay surgeons and shock therapists alike while concentrating

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on not allowing the patient for a single moment to retreat either from his realization that he is insane or from his hatred of the analyst who has succeeded, after so many years, in bringing him to an emotional realization of the facts that he has spent his whole life trying to evade. This may be the more difficult because, when the first panic begins to subside, the patient himself will begin to suggest that he feels better. Due weight must be given to this, but care must be taken to prevent its being used to delay investigation in detail of the ramifications in the analytic situation of the changes brought about in the patient's object relationships by the realization of his insanity.

F. Results

I am not yet prepared to offer any opinion about the prospects of treatment except to say that two of the three schizophrenics of whom I am speaking are now earning their living. I believe that if the course I have indicated above is followed there is reason to anticipate that the schizophrenic may achieve his own form of adjustment to reality which may be no less worthy of the title of ' cure ' because it is not of the same kind as that which is achieved by less disordered patients. I repeat that I do not think that any cure, however limited, will be achieved if, at the point I have tried to describe to you, the analyst attempts to reassure the patient and so undoes all the good work that has led to the latter's being able to realize the severity of his condition. At this point an opportunity, which must not be lost, has been created for exploring with the patient what it means to do analytic or any other kind of work when insane.

The experiences I have described to you compel me to conclude that at the onset of the infantile depressive position, elements of verbal thought increase in intensity and depth. In consequence the pains of psychic reality are exacerbated by it and the patient who regresses to the paranoid-schizoid position will, as he does so, turn destructively on his embryonic capacity for verbal thought as one of the elements which have led to his pain.

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