The 2000 Frieda Fromm-Reichmann Lecture

The Current Relevance of Fromm-Reichmann's Works

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I will discuss the relevance of Fromm-Reichmann's life and works to our current treatment approaches, attempting to set each in their historic contexts. On this 50th anniversary of the publication of *Principles of Intensive Psychotherapy*, how will we at The Washington School develop our legacy? Frieda Fromm-Reichmann lived from 1889 to 1957. She remains an acknowledged pillar of the Washington School of Psychiatry and a patron saint of sorts at Chestnut Lodge, (now owned and operated by CPC Health). However, we do not study her writings systematically. Her two books, never out of print, are available in paperback. *Principles of Intensive Psychotherapy* is the published version of one of her two Washington School courses. Fromm-Reichmann's second book, *Psychoanalysis and Psychotherapy*, is a posthumous compilation of her more important papers. Officially edited by Dexter Bullard, Sr., he thanks Otto A. Will who "initiated the idea of this book" and did "the preparatory work" (Bullard 1959, p. xi). Fromm-Reichmann's other Washington School course, "The assets of the mentally handicapped: The interplay of mental illness and creativity," defines her credo (Fromm-Reichmann 1990). She emphasized that psychotic communication contains meaning, that within every seemingly hopelessly deranged person there is a beleaguered ego. As the therapist persists in reaching out, and respects the patient and his or her struggle, communication gradually becomes clearer, and the person's special talents can flourish. Joanne Greenberg portrayed her well, as Dr. Fried, in her hugely popular autobiographical novel, *I Never Promised You a Rose Garden* (Greenberg 1964).

Fromm-Reichmann passionately sought to bring psychodynamically oriented treatment to the most severely ill. She taught what she considered scientific principles, but Joanne Greenberg emphasized instead Fromm-Reichmann's therapeutic art. Jacob Arlow, writing on a topic Greenberg herself has addressed, delusion and metaphor, said,

> To appreciate what lies behind the ubiquitous metaphoric transformation of reality which the psychotic effects, requires skill, experience, and perhaps a special gift for empathic identification and intuition. These were the qualities which Frieda Fromm-Reichmann exemplified to the greatest degree. Hers was a special ability to understand a patient's metaphoric language, but, more than that, she had the ability to communicate the understanding in a way that helped to

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> create for her patients a bridge that led from metaphor to simile to objective communication. It was her special gift not only to understand the nature of the unconscious conflicts hidden behind the patient's delusions and metaphors, but also to use language that indicated to the patient that he was being understood. This perhaps was the first step on the road to recovery. (Arlow 1989, pp. 181–2)

Fromm-Reichmann expected the therapist to sense a potential empathic interconnection in the evaluative sessions, (Fromm-Reichmann 1950, pp. 62–63) and to strive continually toward a personal experience of the patient's mental state of loneliness and apprehension. Maintaining the same body stance can often give a physiologically resonating sense of the patient's hopelessness and helplessness, she said. We do Fromm-Reichmann a great disservice if we emphasize her "special gift" and then ruefully regret our own mere mortal limitations, as if she, but not we, could do such work. I've heard this far too often from prestigious analysts and others begging off from what I believe is a responsibility of *every* mental health worker. I believe such back-handed praise was part of a political agenda within American classical psychoanalysis which maintained the untreatability of psychosis. Fortunately, as psychoanalysis is less sought-after, these elitist perspectives have softened, and such work is now deemed more relevant and important.

Fromm-Reichmann brought out her patient's creative potential, apparently free of unconscious hostile competitive tendencies. She placed humanistic principles in a scientific context: stressing that we are connected by our common humanity; we all, whether sick or well, want to feel safe, understood, respected, and not feared. Having lived through two world wars, finally leaving her homeland as it deteriorated into genocidal psychosis, she strove to bring order out of chaos, to bring peace where there had been internal war. But she also practiced the political art of dignified accommodation. She chose her battles carefully. The title of Gail Hornstein's forthcoming biography of Fromm-Reichmann is aptly titled *To Redeem One Person is to Redeem the World* (Hornstein 2000).[1]

Her papers proselytize, urging conversion from a notion of hopelessness regarding the treatability of psychosis. She recruited listeners or readers to enlist in this mental health army, and then oriented them to this task. Therapists must be open to their own psychotic aspects as elucidated in their personal psychotherapy and psychoanalysis. The process of self-scrutiny must continue throughout our careers as we struggle with our personal demons. Anxiety in the therapist and defensive projection and denial are the biggest factors inhibiting progress. She saw psychotic process as an extreme amplification of the human conflict between dependency needs and self-sufficiency, in which the patient's envy fuels a fabricated grandiosity leading the patient to dread his or her magical destructiveness. When therapists fear their patients, and especially when they don't acknowledge the fear and thus don't explore its roots, both therapist and patient contribute to obstructing the therapeutic process. She stressed the importance of bringing in a third person, a supervisor either formally or through collegial discussion, to help the therapist get clear about the specifics of the impeding countertransferential processes.

Fromm-Reichmann stressed methods by which therapists could enhance and develop their empathic potential, building upon their respect for the patient. She echoed Sullivan in saying, "Such respect can be valid only if the psychiatrist realizes that his patient's difficulties in living are not too different from his own" (Fromm-Reichmann 1950, p. xi).

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[1] While I have not yet had an opportunity to read the book, I did hear from Joanne Greenberg, who wrote to me on May 8, 2000, "WAIT until you read Gail Hornstein's book!! It is just about everything we all wanted to say about what happened and what has been happening in psychiatry recently—it seems to me she got it all right. Like any really good biography, she does the milieu, but also the writing is good, and the conclusions she comes to are what we all would have wanted."

"Where there is lack of security, there is anxiety; where there is anxiety, there is fear of the anxieties in others. The insecure psychiatrist is, therefore, liable to be afraid of his patients' anxiety" (Fromm-Reichmann 1950, p. 24).

She addressed audiences of social workers, psychiatrists and classical psychoanalysts. She knew that once psychotic patients have gained insight into their conflicts and can manage their enormous anxiety, they are rewarded with sanity and thus a more creative and cohesive life. While just 4′10″ tall, she was not easily intimidated. Her personality was a rare combination of fierce gentleness. Lodge therapist Samuel, or Tommy, Thompson, called her "the gentle giant," adding she "was often mistaken for the housekeeper when she opened the door of her cottage to greet a new patient" (Thompson 1989, p. 217).

Do people remember her, forty-three years after her death? Are new clinicians even introduced to her writings? Recently, I called the San Diego Gallery Old Town, that handles Margaret Bourke-White's Time-Life photos, hoping to track down her famous portraits of Sullivan and to learn how to research the existence of photos of Fromm-Reichmann. I asked the gallery owner if she'd ever heard of Fromm-Reichmann. "Of course I know who she is! She's so famous! Wasn't she married to Erich Fromm? They were one of the couples of the century." And at the recent annual meeting of the Institute of Contemporary Psychoanalysis in Los Angeles, organized by Judith Vida on the theme "Bringing Ferenczi Home," a participant said, "I read Fromm-Reichmann as an undergraduate and fell in love with her work. I decided to become an analyst because of her. But for the following forty years, I haven't heard her name. It is so good now to be hearing about her again."

Has her message become irrelevant, outmoded, a primitive message from the days before we acquired our current psychopharmacologic scientific sophistication, and before our asylums were emptied? Or have we subverted her message, as we accommodate to the complex pressures from (a) managed care firms who would limit insurance company expenses, (b) the pharmacologic industry pushing to maximize profits, (c) National Alliance for the Mentally Ill (NAMI)'s efforts to stop professional groups from blaming parents? Have her recommendations been generally accepted, and their author gradually less acknowledged? Or do the current complex pharmacologic regimens chronically block affective pathways that are vital for the passions of both hate and love, outbursts and creativity, transference distortions and resolutions?

I am disappointed to see how rarely Fromm-Reichmann is currently cited, and am reminded of how New York State lost its highest waterfalls and how Naomi Bliven and her husband re-discovered Katterskill Falls. At the heart of the story is nostalgia, the pure falling water representing for me childhood tears, mother's milk and mother's tears, the mystery of gravity, the knowledge of our mortality, and the possibility of choosing to fall to one's death. Katterskill Falls is situated deep in the sometimes rugged Catskill Mountains, but is just seven miles from the New York State Thruway, and not so far from the towns where Harry Stack Sullivan and Harold Searles grew up. The falls are 260 feet high, about 100 feet taller than Niagara Falls, but are narrow, conveying comparatively negligible water. They form the center of the area called "the birthplace of American art." Since beginning in 1825, Thomas Cole and his followers in the Hudson River School came there to paint the idyllic and rugged scenes, in a time "when artists and writers in New York turned to the wilderness as a metaphor for our uncorrupted young nation" (Bliven 1987, p. 54). Katterskill Falls became a popular vacation spot, and people flocked by railroad and then stagecoach to its 400-room Catskill Mountain House, (which I, of course, link with Chestnut Lodge's Main Building).

Then, as the automobile changed America's vacation agendas, the area's popularity declined, the hotels fell into disuse, and in the 1960s New York State bought the land and burned the decaying hotel; the railroad line rotted away. Local people forgot the now inaccessible falls even existed. Naomi Bliven and her husband, both art historians, happened to

vacation in the area. They experienced déja vu in this place where they had never been. Naomi Bliven realized that nature was imitating the Hudson River School artworks, and, knowing the Katterskill Falls was the area's main attraction, became obsessed with finding it. After three summers of arduous and sometimes frightening expeditions and study, they reached the falls. Bliven writes, "... at intervals below the brink, jutting rocks broke into the tearing stream and interrupted the column of water, opening it up in a pattern that was repeated over and over. The falls looked like a ribbon of lace being continuously woven. I have never seen a combination of such extreme power and such extreme delicacy" (Bliven, p. 58).

I link this image with Chestnut Lodge, when forty to seventy patients were treated in analysis by a small team of ambitious doctors who spent much time discussing and chronicling their observations. Their papers seem like the boulders and ledges interrupting the flow of direct clinical work, sending delicate yet powerful messages to the world about the intricacies of psychotic existence and its amelioration. The Lodge set the standard for treating people suffering psychoses. It had, in its golden days, waiting lists where both patients and doctors waited for two years for a place. These were days when the alternative for patients was to languish in vast barren warehouses of chronicity—enduring neglect, boredom, poor nutrition, and violence. Now, patients may either maintain medication compliance and attend programs aimed at helping them with socialization, or they can abandon these efforts, more often becoming homeless, intermittently incarcerated in jails or prisons rather than being hospitalized. I am not saying, however, that I would turn back time to an idealized past. Having worked at two state hospitals in the early 1970s, when sending a patient to the chronic ward meant a sentence of warehoused oblivion, I am clear that problems for the mentally ill were daunting then as now.

Now it is not the automobile but the emphasis on psychopharmacology and the deemphasis of psychodynamics that have changed not vacation but referral patterns. Today, one can too easily view Katterskill Falls. There's a well-marked parking lot, a paved path about a half-mile long, leading to the foot of the falls. There's no adventure along the way. One leaves with a ho-hum feeling, unless one is there in springtime. These changes resonate with those at the Lodge over my twenty-four years there, the first ten during the non-medicating era. Then, my patients and I formed an intense and ambivalent bond. Now, although, or *because*, my patients are less symptomatic initially, we are less attached to each other. There's more politeness, more distance. Years ago, I gave a paper at the International Symposium on the Psychotherapy of Schizophrenia (ISPS) on the fascinating Chestnut Lodge Wednesday Conferences. Some years later, an Italian purposefully put this event on his itinerary. Unfortunately, the discussion revolved around nuances of medication. He was perplexed and judged the event boring. Joyce McDougall was similarly disenchanted. "It's all medications!" she whispered to me. "Where's the analysis?"

Fromm-Reichmann had had her own surprising comment on medications in an early 1940s Wednesday Conference where staff contemplated prescribing insulin, barbiturates, or benzedrine. "Do you want to knock him out completely or give him enough to relax and then be able to talk to you as he comes out of it.... It seems you should give [the medicine] but not deprive him of his doctor" (Silver 1989, pp. 28–29). In the late 1950s through the early 1980s many (but by no means all) on the Lodge staff saw medication as muting and thus avoiding the patient's aggression and the patient's fear of his destructive potential. An interesting seminar on drugs was held there, transcriptions surviving for eight of its meetings, held between May and December of 1961.[2] Medicating was like paving the path to the waterfalls. I could find no record of any comments by Fromm-Reich-

[2]Those participating included Drs. Donald Burnham, John Fort, Kenneth Gaarder, Harry Hinson, John Kafka, Berl Mendel, George Nesbitt, Clarence Schulz, Michael Woodbury, and Mr. J. Kroll.

mann regarding chlorpromazine, which was introduced in 1955, the year before her one-year sabbatical in California. Fromm-Reichmann returned to work at the Lodge, but by then she was rather deaf and rarely commented at the conferences. She died in April of 1957 at her Lodge cottage, following a heart attack. She had been working on a paper, "Loneliness" (Silver 1996b).

I will now review Fromm-Reichmann's life story, partly to pay tribute to the intellectual adventure it contains, but also to emphasize the diversity of her perspectives, and the quality of her affiliations. In our current adversities, review of those she faced could give us new insights. She often said, "If you want to know something for my epitaph, then I think we could say I wasn't lazy and I had lots of fun, but of another type as compared with many other people. It was a special type of fun" (Silver 1989, p. 481).

Fromm-Reichmann was born in Karlsruhe, in southwest Germany (Fromm-Reichmann 1989). Her father, having failed in a business venture, was hired on as personnel manager in his wife's brother-in-law's bank in Koenigsburg, where he became very popular, revered for his interpersonal skills. His wife called him Zipf—short for "Principles"—he was a pillar of the Orthodox Jewish community there. Frieda was the oldest of three girls, and said the younger ones had a rough time, since she turned out, to a T, just like what her mother hoped for. Mother suffered from familial deafness that she tried to keep secret. But Frieda knew from the time she was nine, since her mother could not hear her when she stood behind her braiding her long hair. Mother was extremely ambitious for her girls and was one of a group establishing a girls' school to prepare the daughters for university training, which finally became available in 1908.

Frieda's mother had a sister, Helene Simon, who was prominent in the Weimar Republic government, and wrote two popular books on Robert Owen, a humanitarian industrialist of the early 19th century (Simon 1919 & 1925). Owen believed strongly that the best way for a factory to maximize profits was to attend to the health, welfare, and education of its workers and their families. He introduced the concept and development of early childhood education, and Simon's efforts contributed to the establishment of kindergartens in Germany. This aunt said to Frieda, teasing her about her efforts to get everyone around her to behave properly, "You should own a dog, so you could have trouble with it, too." Thus, Frieda grew up in an extremely supportive matriarchy, and with a formidable aunt as a role model in humanitarian leadership.

Frieda's father encouraged her study of medicine, and her uncle, his boss, financed this, as he would her sanitorium in Heidelberg years later. The sanitorium was a smaller but more substantial version of the Lodge's Main Building; and Dexter Sr. in some ways replaced this uncle. In internship, she attended some lectures by the great Kraepelin and was disgusted by his lack of respect for the patients. Her medical school mentor was Kurt Goldstein, the founder of holistic psychiatry, author of a classic text, *The Organism*. Goldstein's were among the first published criticisms of Freud, challenging him to present his data in a scientific testable fashion. Fromm-Reichmann's 1913 medical school dissertation was on the pupillary reflexes of schizophrenic patients (Reichmann 1914).[3] Recent articles have appeared reporting discovery of these same findings, eighty years later.

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[3]In a section Fromm-Reichmann underlined in the copy of *The Organism* given to her by Goldstein, he said, "When psychoanalysis apparently finds a confirmation of its original assumptions through new observations, we must remember that we were able to state the same about the reflex theory, namely, that on the basis of reflexology, no criticism of the reflex theory is possible, because the principle itself always supplies auxiliary hypotheses to repair the shortcomings. The apparent confirmation of the basic psychoanalytic theory by further experience leads to the same fallacy, because the new experiences are always obtained in the same way. In psychoanalysis, there is, in addition, a special factor which helps to discover an increasing number of apparent confirmations for the basic theory. Because the analytic doctrine is so widely known, through the spreading of analytic literature, we cannot be surprised that we find, in the free associations, so many confirmations of the analytic thesis" (Goldstein 1939, p. 330).

She was a Major in the German Army during World War I, where she administered the hospital for brain-injured soldiers assigned to Goldstein. She understood the neuroanatomy and neurophysiology of her day as well as military regimentation and the skills for maintaining discipline. At the Lodge, she found that the rehabilitation protocols for brain-injured soldiers applied amazingly well to mind-injured civilians, who had suffered psychotic breakdown (Reichmann 1917). The guiding principles included: (1) keep your statements short and simple; (2) keep the environment consistent regarding the placement of things and the schedule of events; (3) develop an orderly step-wise progression of attainable goals; (4) be clear with the patient about your understanding of the situation and about your responses to his statements and actions; and (5) find and foster the patient's healthy aspects.

After World War I, she worked for a while at I. H. Schultz's sanitorium, Weisser Hirsch, in Dresden. Schultz was perhaps the first German to apply psychodynamics to a hospital population. He introduced Fromm-Reichmann to Freud's writings on transference, and she took to them immediately, having noticed there was something very important that happened between patient and doctor, which some doctors abused, bragging about how their patients loved them so much and followed them everywhere. Later, at her own sanatorium in Heidelberg, she had her own transference entanglement. She and her patient and sanatorium co-worker Erich Fromm fell in love, stopped the analysis, and soon married. This is not quite as wild as it seems. They had met earlier, when he was dating a girlfriend of Frieda's, Golde Ginsburg (Burston 1991, p. 15). The two broke with orthodoxy, going to the park and eating bread on Passover, then closed the sanatorium and set off to the Berlin Psychoanalytic Institute both to be analyzed by Hanns Sachs. Karen Horney was on the faculty (Fromm-Reichmann 1927 & 1995a).

During the Heidelberg years, Fromm-Reichmann worked closely with Georg Groddeck, the analyst who suggested the term "id" to Freud, and who has been called the founder of psychosomatics. Harold Searles credits him with being the first to have noted the phenomenon, in the early 1920s, of the patient as therapist to the analyst (Searles 1979, p. 446).[4] Groddeck was a very creative speaker, who could hold forth extemporaneously at length, much like Sullivan, and Erich Fromm, whose words seemed to fall from their mouths already typeset and ready for publication. In each case, Frieda became that person's mediator, helping them maintain their connections with the major professional organizations. I now see that she treated them with the same respect and delicate mixture of sternness and deference that characterized her work with her sometimes highly explosive Lodge patients.

Freud had earlier recommended to Sándor Ferenczi that he get to know Groddeck, and thus, Ferenczi and Fromm-Reichmann knew and respected each other, both of them working intensively with Groddeck. Ferenczi and Fromm-Reichmann scheduled weekly sessions at Groddeck's sanitorium during the summer of 1927, according to a letter Ferenczi wrote to Freud: "I am expecting for next Sunday the announced visit of the Southwest Germans (Landauer, Happel, perhaps Meng, Herr and Frau Dr. Fromm-Reichmann). Frau Dr. Fromm-Reichmann is coming over to me once a week from Heidelberg. She is an astute, analytically extremely talented person.[5]" I am grateful to Ernst Falzeder

[4]"The first writing, to my knowledge, which at all explicitly describes the patient's functioning as therapist to the doctor is Groddeck's (1923) *The Book of the It*. It is noteworthy that even this courageously pioneering statement portrays the therapeutic process at work as being, in essence, therapy *for the patient*, exclusively, in the long run; nonetheless, Groddeck is a pioneer of high courage in his reporting" (italics his).

[5]German original: " . . . erwarte ich für nächsten Sonntag den angesagten Besuch der 'Südwestdeutschen' (Landauer, Happel, vielleicht Meng, Herr und Frau Dr. Fromm-Reichmann). Mit mir und Groddeck zusammen wird es eine ganz stattliche Zahl werden.—Frau Dr. Fromm-Reichmann kommt von Heidelberg wöchentlich einmal zu mir herüber. Sie ist eine kluge, analytisch äusserst begabte Person." Ferenczi to Freud 19 August 1927.

for e-mailing me this quotation as soon as he had discovered it, in his preparation of Volume 3 of *The Correspondence of Sigmund Freud and Sándor Ferenczi.*

This was clearly a letter of introduction, and yet it seems that Fromm-Reichmann never followed up on this and apparently never met with Freud. Did she avoid him? Had her earlier work with Kurt Goldstein, who was such an outspoken critic of Freud's lack of scientific method, left her feeling too vulnerable? Did she want not to be linked with Ferenczi and the women clustering around him? And Fromm-Reichmann's orderly principled self and her libidinal self had collided less than a year earlier, and she just might not have wanted to present all that to Freud. I wonder, how might she and Glen Gabbard debate on erotic countertransference? And as Ferenczi currently is experiencing enthusiastic scholarly attention, might Fromm-Reichmann now find it safer to acknowledge their shared intellectual lineage?

Frieda had yearned for children, and had loved obstetrics. But Erich had feared kids would disrupt his writing career. The marriage lasted less than five years. Erich, after completing treatment for tuberculosis in Davos, Switzerland, came to the United States as World War II loomed (Silver 1999). Frieda went first to Alsace-Lorraine, then to Palestine with her mother and sisters. Her father had apparently suicided in 1925, by staging an accidental fall down an elevator shaft, this when he, like his wife, had become severely deaf. He died the year before Frieda's involvement with Erich, and so I imagine a manic aspect to her falling in love just then. She said her father had been worried sick about the family, none of the girls married, and with two deaf parents. She added she got terrible migraine headaches on the anniversary of his death. She would later write eloquently on manic-depressive illness, on migraines, and, as her own hearing impairment deepened, on loneliness.

From Palestine, Frieda soon came to the United States, Erich having called Ernest Hadley, Dexter Bullard, Sr.'s analyst. Hadley asked Bullard if he could use a German-Jewish refugee at his hospital, Chestnut Lodge. Bullard at first said no, but needed coverage for the summer. It was, he often said, "love at first sight." Bullard had vaguely thought of making the hospital psychoanalytic in its orientation, and Fromm-Reichmann knew exactly how to do this. They teamed up, and created an institution that was the beacon to the world on the psychoanalytic treatment of the psychoses (Silver 1989). Fromm-Reichmann arrived here already fluent in English. In 1935, the year of her arrival, she gave a talk at the Washington Psychoanalytic Society on Female Psychosexuality (Fromm-Reichmann 1995b). It is formidable, resonating with the ideas of her teacher at the Berlin Psychoanalytic Institute, Karen Horney. I found the manuscript in the Lodge archives along with a letter from Lucille Dooley supplying bibliographic information Frieda had requested towards publishing the paper. She never did so, and I wonder why not. But it is now in the *Journal of the American Academy of Psychoanalysis* (Fromm-Reichmann 1995b).

Fromm-Reichmann was an extremely popular speaker and thus advertizer for the Lodge. Harold Searles told me that when Fromm-Reichmann went to the Stanford University Center for the Advanced Study of the Behavioral Sciences in 1956, she set out for the year's sabbatical already having received a staggering thirty-six speaking invitations. She sold the product. For example, in the Academic Lecture she delivered in 1954 at the 110th annual meeting of the American Psychiatric Association in St. Louis, she said,

> My experience during the last twenty years has been mainly with schizophrenic patients who came to our hospital in a state of severe psychotic disturbance, from which the majority emerged sooner or later under intensive dynamic psychotherapy. After their emergence, they continued treatment with the same psychiatrist through the years of their outwardly more quiet state of illness, with the aim of ultimate recovery with insight. During both phases the patients were seen for four to six regularly scheduled interviews per week, lasting one hour or longer. Sometimes relapses occurred. Such relapses were due to failure in therapeutic skill and

> evaluation of the extent of the patient's endurance for psychotherapy, to unrecognized difficulties in the doctor-patient relationship, or to responses to intercurrent events beyond the psychiatrist's control. As a rule, these relapses could be handled successfully if the psychiatrist himself did not become too frightened, too discouraged, or too narcissistically hurt by their occurrence. (Bullard, p. 196)

This certainly gave members of the audience a sense that patients they referred to the Lodge would recover or improve markedly, or if they themselves worked at the Lodge, their therapeutic prowess would be transformed. Meanwhile, as Robert Cohen has said, those working at the Lodge in those years were chronically discouraged by the obdurate nature of schizophrenia. They *needed* the small group meetings and the system wherein everyone was in ongoing supervision, to keep their spirits up. Even with this, very many doctors stayed on the Lodge staff only a few years and then moved on, both for better earnings and a greater sense of professional gratification.

McGlashan's follow-up study of all the patients at the Lodge between 1950 and 1975 told a different story from Frieda's. While 80 percent of those who today would be diagnosed as suffering a borderline personality disorder essentially recovered, only one third of the patients with schizophrenia were significantly improved, and only one third of these could be called markedly improved or recovered. He declared at the 1983 Lodge symposium, "Dexter Sr. and Frieda embarked on a grand experiment. But the results are in; the experiment failed." However, to have one third significantly improved years after completing treatment, having chronically defeated many prior treatment efforts is not such a dismal result. But still, it is not the result Fromm-Reichmann intimated.

Soon after the completion of the follow-up study, Drs. McGlashan and Dexter Bullard, Jr. and some other members of the senior staff interviewed each of the medical staff regarding their views on psychotropic medication. I was told that I had been the most conservative, as I had advocated keeping some unit running in the Lodge tradition of an initial phase off meds, and with availability of cold wet sheet packs. This did not happen, and now as far as I know all Lodge patients are receiving complex medication regimens, and packs were discontinued many years ago. I don't know of any place in the world where psychotic patients are worked with dynamically without reliance on medications, nor where it is possible for patients to receive the physiological and psychological benefits of being in cold wet sheet pack. Meanwhile, Fromm-Reichmann had said at a Wednesday conference, ". . . as long as the meds don't deprive the patient of the doctor . . ." Perhaps she would be an enthusiastic champion of the pharmacologic advances, and would chide me for an inability to grow with the times.

I have worked at the Lodge for over two decades, the first ten years still when patients were weaned off their medicines, and when cold wet sheet packs provided the containment of an artificial psychological skin. When I re-read my papers from that era, I like them more than my recent reports. I know the Falls are there, but see the paths becoming overgrown, and the hotel falling into ruin, as American psychiatry and psychoanalysis essentially unanimously view schizophrenia as a biological disorder one manages with pharmacology, ECT, and external support systems. I worry that while these medications clearly diminish psychotic symptomatology, they seem to interfere with specific neuronal transmission, inhibiting particular pathways so that patients are not flooded with unmanageable affects, primarily anxiety and secondarily fight-flight responses and related justifying ideation. Does the secondary brain neuron atrophy when chronically understimulated, like muscle fibers kept too long in a cast? Three of my early Lodge patients, who had been chronically psychotic, and were treated with psychodynamic approaches but without meds, went on to enduring marriages, and one is mothering her three kids. In the post-medication era none of my patients has gained the necessary self-confidence to make such commitments, neither to another person nor to a career path, nor to a location claimed

as home. We don't form that same intense ambivalently symbiotic bond that characterizes the early phase of work, without meds, as Searles described. I believe this second reexperience of a parent-infant bond is vital for resumption of autonomous striving.

While these prescribed chemicals produce greater calmness and coherence, they may come with a price of neuronal deaths, and thus lost creativity. My friend Laurice McAfee interviewed Joanne Greenberg in her home near Denver, and reported on the interview at the 1985 Lodge symposium: Joanne described her first cold wet sheet pack, a technique for containing agitated patients, that dates back to the 1800s, in which the patient is wrapped for two hours in ice-soaked sheets, which soon warm up, creating a steam-bath cocoon effect. These are now considered too restrictive, while the benzodiazapines would seem to do the job much more humanely. Joanne said,

> I was on Main IV, having a very tough time. A doctor, whom I don't remember—since I subscribed to the theory that if you've seen one person, you've seen them all—said, 'I think you need to be in one of these.'... [F]or me it was the first time that I was ever able to look down into my mind, to get clear, to be clear. Once that happened to someone who had never had that, I think he would do anything on earth to get it again. That kind of stillness had a clarity, all of that yelling that went on all of the time inside me, wasn't there and I was at the end of it... I knew that the ability to stop dead and look inside myself was what well people have. And I knew that that high feeling in the pack was coming from me, not a drug. I learned for the first time that there's a difference between inside and outside and that inside then became available to me. Once I saw that, once I learned that, I would do anything to promote it. (McAfee 1989, pp. 520–521)

You may be wondering whether I will get to the issue for which Fromm-Reichmann is currently most cited, in scornful comments regarding the so outmoded, damaging and erroneous labeling of the "schizophrenogenic mother." Fromm-Reichmann used this term, consolidating Sullivan's thoughts on the baby who cries out of hunger, hears then the approach of the anxious mother, and cries out of a wish to escape her (Hartwell, Dolnick). Fromm-Reichmann said in her 1948 paper, "Notes on the development of treatment of schizophrenics by psychoanalytic psychotherapy", a paper published first in *Psychiatry*, "It is true that the schizophrenic is hit by initial traumatic warp and thwarting experiences at a very early period of life, when he has not yet developed a marked and stable degree of relatedness to other people. It is also true that the final outbreak of schizophrenic disorder will be characterized by regressive tendencies in the direction of this original early period of schizophrenogenic traumatization" (Bullard, p. 161). She added, (Bullard, p. 163) that the schizophrenic is highly conflicted regarding withdrawing from and resuming interpersonal relating, since the withdrawal is defensive in nature. "He is frequently very willing to break through his self-imposed withdrawal if the analyst has been successful in overcoming the schizophrenic's well-founded suspicions, not only of the significant people because of whose malevolence he originally withdrew, but later of the members of the human race at large, including himself and the psychoanalyst" (Bullard, p. 163). "The schizophrenic is painfully distrustful and resentful of other people, because of the severe early warp and rejection that he has encountered in important people of his infancy and childhood, as a rule mainly in a schizophrenogenic mother. During his early fight for emotional survival, he begins to develop the great interpersonal sensitivity which remains his for the rest of his life" (Bullard, pp. 163–4). "I do not believe, as many classical psychoanalysts do, that man is born to be hostile. However, the personal hostility which is engendered by the early pathogenic warp, rejection, and malevolence he has encountered is among the serious psychopathological problems of the schizophrenic" (Bullard, pp. 173–4). She kept these views right up to her death. In the posthumously delivered paper, "Basic problems in the psychotherapy of schizophrenia," Otto Will would read in Zurich, "One of the great problems of all schizophrenic patients is, of course, their difficulty in dealing with their

hatred and their potential violence, both engendered by the severe warp inflicted upon them by significant environmental figures of their early infancy—in this culture, primarily by the mothering one. Because of the narcissistic, infantile elements in the schizophrenic's self-appraisal, he overrates the effectiveness of his hostility and of his actual and fantasied violence. Therefore, he feels an exaggerated guilt about both" (Bullard, pp. 210–211).

But Fromm-Reichmann had also said at a Lodge Wednesday Conference, "the patient will change his attitude towards his parents over the course of effective treatment . . . we are the instrument for that." Joanne Greenberg has repeatedly said that at no point in her work with her did Fromm-Reichmann impugn her mother's efforts or character.

Thus, it seems that Fromm-Reichmann vacillated between thinking of the pre-schizophrenic's mother as bad and as "bad," in quotes—that is, between thinking that she herself could have done a far better job had that baby been hers, and on the other hand, thinking of the "bad mother" as the patient's construct, borne of intensified frustrations. This is analogous to Freud's vacillations regarding actual or fantasied sexual abuse as etiologic of hysteria, as discussed in Nicholas Rand and Maria Torok's extremely readable book, *Questions for Freud: The Secret History of Psychoanalysis*. Studying Ferenczi's classic papers that are now gaining such deserved attention, in which he talks about the effects of actual childhood sexual abuse, including dissociative disorders, I find much that resonates with Fromm-Reichmann's works. For example, Ferenczi says,

> Human beings are a part of the environment, differing greatly in importance from all other objects in the world, particularly in one significant respect: all other objects are always equable, always constant. The only part of the environment which is not reliable is other persons, particularly the parents. . . . The human being is the only animal which lies. It is this which makes it very difficult for a child to adapt itself to the parental part of its environment; even the most respected parents do not always tell the truth, they lie deliberately, though—as they think—only in the interests of the child. (Ferenczi 1928, p. 72)

and "I have slowly come around to the critical point of view that psychoanalysis has restricted itself to the analysis of either obsessional neuroses or the neurosis of character, while it has neglected the organic-hysterical foundations of psychoanalysis itself. The reason for this is the overvaluation of fantasy and the underestimation of traumatic reality in pathogenesis" (Ferenczi's letter to Freud, 29 December 1929. Quoted in Rand & Torok 1997, p. 118), and "Freud's metapsychological constructions result from experiences with neurotics (repression). It is equally legitimate to take seriously, as a form of psychoanalytic reality, the rather different and yet nearly universal mechanisms that lurk behind the [mental] productions of psychotics and traumatized people (fragmentation and atomization of the personality; sequestering)" (Letter to Freud, 31 May 1931, which included an abstract for a proposed lecture: these are quoted in Rand and Torok, on pp. 118 and 119).

I think that part of Fromm-Reichmann's dilemma related to her own complex loyalties, to Groddeck and Ferenczi and Sullivan and Freud, and to the various institutions she worked to form and maintain, which themselves were often in conflict. She followed a pattern typical of women breaking into professions dominated by men, as described by Robin Muncy in her 1991 book, *Creating a Female Dominion in American Reform*, in that Fromm-Reichmann defined her lay sisters as lacking adequate competence, a situation she the professional could correct. Her frustrations over never having been a mother seem absolutely relevant. In any case, just as Fromm-Reichmann laid the blame for a failed treatment on the doorstep of the therapist who had not mastered his or her anxiety, so too did she lay blame for the outbreak of illness on the doorstep of the mother and the mother's ambivalence. In both cases, the non-psychotic party, the parents or the transferential parents are held responsible for causing or continuing the illness. The backlash against such accusation has been enormous, and still

continues, fueled both by many parents and many psychiatrists. Any treatment that would include talking about the past has been ruled upsetting, regressive, and thus harmful.

The 1998 PORT study (The Schizophrenia Patient Outcomes Research Team Treatment Recommendations, headed by Anthony Lehman and Donald Steinwachs), which is quoted in NAMI's brochure on schizophrenia and the recent Surgeon General's report states,

> Individual and group psychotherapies adhering to a psychodynamic model (defined as therapies that use interpretation of unconscious material and focus on transference and regression) should *not* be used in the treatment of persons with schizophrenia. *Rationale.* The scientific data on this issue are quite limited. However, there is no evidence in support of the superiority of psychoanalytic therapy to other forms of therapy, and there is a consensus that psychotherapy that promotes regression and psychotic transference can be harmful to persons with schizophrenia. This risk, combined with the high cost and lack of evidence of any benefit, argues strongly against the use of psychoanalytic therapy, even in combination with effective pharmacotherapy. (Review reference: Scott, J.E, and Dixon, L.B. Psychological interventions for schizophrenia. *Schizophrenia Bulletin*, 21 (4): 621–630 1995, p. 623; Level of evidence: C Recommendation based primarily on expert opinion, with minimal research-based evidence, but significant clinical experience.)

The ISPS-US (The International Society for the Psychological treatment of the Schizophrenias and other psychoses, the United States Chapter) plans to explore these issues, debating with the authors of the PORT study, at our next meeting, the day after the Lodge Symposium, Saturday, October 7, 2000. We must move beyond casting blame, and recognize that those who will be or have become psychotic, as well as those close to them, all struggle with enormous anxiety and self-doubt. They need a safe relationship in which to work over and contain their welter of confusing thoughts and frightening feelings. Fromm-Reichmann made her mistakes, but depriving those labeled schizophrenic of insight-oriented therapy seems mistaken as well.

The ISPS began in the mid 1950s, with Fromm-Reichmann as one of its founders. It held meetings every three years in Europe and the United States on the psychoanalytic treatment of schizophrenia. In 1994, David Feinsilver led the effort to convert this casually structured group into an ongoing society, with various national chapters. We are beginning to form city-based branches, and currently hold open meetings held at the Washington School.

It would seem that in the United States there is a current consensus that schizophrenia emerges in adolescence or young adulthood, due to some limbic system storm, unrelated to earlier dynamics. At first, I found it hopeful that Scandinavian studies are finding that early family intervention for children who seem odd or extremely anxious in their preschool years is leading to a decreased incidence of schizophrenia (Alanen 1997a and b; Tienari 1992). I imagined a primary prevention initiative that would be dynamically oriented. However, the efforts of Tom McGlashan and his Australian colleague, Patrick McGorry, which were reported some months ago in the *New York Times*, have moved now to the formation of the International Association on Early Psychosis. They aim to identify these at risk children, starting them on antipsychotic medication, to prevent adolescent decompensation.

Perhaps the current outrage over the escalating use of Prozac and Ritalin in two and three year olds will push the National Institutes of Health to fund long-range prospective research, comparing psychodynamic, pharmacological and other interventions with no intervention for children at risk. Clearly people who later develop schizophrenia showed a heightened sensitivity to anxiety from their earliest days. They influence their *parents'* abilities to communicate effectively, as Denise Fort (1990) has demonstrated. Perhaps now, with increasingly sophisticated non-invasive ways of measuring brain neuronal activity, we soon will monitor such patterns in normal, and schizophrenic, and vulnerable individuals. At that point, perhaps we will demonstrate objectively and with statisti-

cal validation, the power of insight oriented psychotherapy gradually to re-wire brains, with decreasing primitive flooding of anxiety, and increasing ability to process affect safely and constructively. Only then do I think Fromm-Reichmann's work will be studied with the vigor it deserves. Recent reports by Panksepp and others, in the new journal, *Neuro-Psychoanalysis* give actual promising data.

What is the relevance of Fromm-Reichmann's teachings in an era of hospital closures, cut-backs, downsizings, attacks on privacy, insistence on productivity? Who will sit with a psychotic patient frequently and patiently, working toward a shared understanding? Why train for something when there is no market for one's services, or when such activity might harm one's professional standing? Quoting Michael Winerip, "The state of the nation's shattered mental-health system all but assure(s) . . . calamities" (Winerip 1999, p. 42). "In 15 years of reporting on mental health, I have never seen the system in such disarray" (Winerip 1999, p. 48).

The public and private sectors of the mental health field have made disastrous accommodations to managed care firms. Training programs so deteriorated under these business pressures that a survey two years ago found psychiatric residents to be the most dissatisfied group of medical specialty trainees. Fromm-Reichmann's name is usually unknown to them since their programs had markedly downscaled instruction in psychodynamics.

Searles, in 1975, railed against the already strong reliance on pharmacologic agents. "Patients [with schizophrenia] have written off their fellow human beings as not kin to them, [and] . . . their fellow human beings have come to accept this as functionally true. If the psychoanalytic movement itself takes refuge in what I regard essentially as a phenothiazine-and-genetics flight from this problem, then the long dark night of the soul will have been ushered in, not only for these vast numbers of schizophrenic patient . . . but also for those relatively few psychoanalysts who are particularly interested in this field (Searles, in Gunderson and Mosher, pp. 227–8).

That time has come. Even those of us persevering in this work never actually fully meet our patients, but work with them for years or decades while they ingest powerful mind-altering drugs. Few mental health professionals work for more than a few minutes with a patient suffering psychosis who is not medicated. Team members, when confronting a crisis, ask for adjustment in the medications without taking the time to ask about the current crises either in the therapy or in the daily life of the patient. Unless we are willing to be with our patients in the agony of their confusion, to enter into the mental mess, to hear and feel our patients' fundamental issues and partial solutions, we can't ask them to grapple with the agony of risking trusting us. We are not entitled to ask for the development of a true transference psychosis, which I believe is necessary for gradual recovery.

And we can not do such work without a strong and safe hospital home for them and us. A nursing mother and infant need providorship, protection, and security. The infant needs to know that her helplessness is recognized and respected by the care-giver, and that the world is a safe enough place in which to explore. The same goes for the treatment dyad who require a surrounding and containing community or treatment team. All psychotic patients here live in a country whose constitution declares its citizens have "certain inalienable rights and among these are life, liberty and the pursuit of happiness." I believe psychotic patients all are entitled to their own mental health professional who carries long-term responsibility for their care, and who is not so burdened as to feel resentful spending time with each of them, frequently. And those professionals need support: courses, conferences, study groups, and supervision, so they can, like Frieda, say they've worked hard and had a special kind of fun.

How can we apply Fromm-Reichmann's orientation in today's fractured mental health systems? I could not recommend that patients with schizophrenia receive analytic treatment and no medications. I know of no

place in the country providing the necessary containment for this work. Even mentioning it here seems insanely outside the standard of the community, especially given the greatly improved, newer, "atypical" antipsychotic medications which are far less strait-jacketing than were the phenothiazines.

Fromm-Reichmann's final paper, left incomplete at the time of her death, was titled "Loneliness." She asserted that the psychiatric profession has focused on anxiety but has ignored the enormously more agonizing affect of loneliness, which she said "leads ultimately to the development of psychotic states. It renders people who suffer it emotionally paralyzed and helpless" (Fromm-Reichmann 1959, p. 3; Bullard, p. 326). She felt that what is termed loss of reality was really an expression of this loneliness. "Loneliness seems to be such a painful, frightening experience that people do practically everything to avoid it. This avoidance seems to include a strange reluctance on the part of psychiatrists to seek scientific clarification of the subject" (Fromm-Reichmann 1959, p. 1; Bullard, p. 325). She refers to "the states of mind in which the fact that there were people in one's past life is more or less forgotten and the hope that there may be interpersonal relationships in one's future life is out of the realm of expectation or imagination" (Fromm-Reichmann 1959, p. 5; Bullard, p. 327). "Only as its all-engulfing intensity decreases may loneliness enter into fusion with anxiety" (Fromm-Reichmann 1959, p. 7; Bullard, p. 330).

Fromm-Reichmann grappled with these ideas as she endured increasing deafness (Silver 1996). She hardly contributed at any of the Lodge Wednesday Conferences she attended in the final year of her life. Now the world seems deaf to our pleas for a humane and unpressured approach to the treatment of psychosis. We therapists are enduring our own loneliness, isolation, apprehension, and fury. I hear the phrase "the field of mental health" too often as "the field of mental hell." The mentally ill who struggle with profound insecurity, uncertainty regarding their boundaries or their very humanness are left to figure things out on their own, and to comply with lifelong medication regimens. Research by psychopharmaco-epidemiologist Julie Zito and colleagues on the escalating prescription patterns of Ritalin and Prozac in two and three year olds has raised the public's awareness and outrage (Zito et al. 2000). Perhaps it will presage funding by NIMH to examine prospectively the relative contributions of early family intervention and psychodynamic approaches and of medications in mitigating later decompensation. I hope there will be controlled studies to monitor organizational efforts, such as McGlashan's and McGorry's in their newly established International Association on Early Psychosis. We should not simply encourage prescription of antipsychotic medications to children who seem at risk for a later adolescent psychotic breakdown.

But I am encouraged by a recent new interest among psychiatric residents in interpersonal work with very ill patients. The military residency program, where I teach, supervise, and serve as a training psychotherapist, is among the very few residency programs that include an experience of training psychotherapy as an elective. Not long ago, earlier classes were firmly committed to the biologic advances, and showed much resistance to acquainting themselves with the psychodynamic literature. Now, they are reading Lodge papers with real interest, bringing in related vignettes from their own work. As the psychiatric residents seem to be finding their way back to a humanistic outlook, there may come a growing resistance to this insane push for efficiency, and once again, a therapist may be able to say to an anxious patient, "We have time," two unique individuals forming a unique partnership. As I worked on the finishing touches on this paper, one of these residents e-mailed me, alerting me to a recent article, "Loneliness as a Component of Psychiatric Disorders" by Richard Booth, Ph.D. It appears in an internet journal, at medscape.com. Ron Munoz, past president of the American Psychiatric Association, also alerted its e-mailing members.

The article begins, "In 1959, Fromm-Reichmann published an article in *Psychiatry* simply entitled "Loneliness," which became one of the catalysts for structuring later sys-