possible interpretation was that light could enter his eyes, the mechanical function of vision was intact, but *nothing* came out. It is as if the internal fire was extinguished or dampened. When my patient came out of his catatonic stupor, his eyes immediately came to life and looked friendly. What troubles the observer about the eyes of the schizophrenic is their lack of expression. Just as the face is masklike, so are the eyes expressionless. The schizophrenic is not without feeling, what he lacks is the ability to focus that feeling upon another person. Here, again, we see the lack of motor coordination manifested in the difficulty of body expression.

There is a difference between seeing and looking. The dictionary tells as that the former is a passive function. The definition of the verb "look" is interesting. I quote: "to direct the eye toward anything, to direct the vision with a certain manner or feeling."* The schizophrenic sees but he doesn't look. He hasn't available in the head segment the motor impulse necessary to "direct" his regard. It is the same lack which accounts for the flat, dull, lifeless expression in the region of the forehead between the eyes and for the emptly feeling in the front of the head. The energy is blocked in the back of the neck and sometimes in the back of the head. It does not come through to the front part of the brain or head.

It is not an easy task to bring this energy through and to hold it in the eyes. To achieve this it is also necessary to increase the charge at the genital region and to hold it there. In one of my most favorable cases this took six months of sustained bioenergetic therapy. But we seek even more. We seek to strengthen the energy swing and to anchor it in the functions of reality so that it can withstand the pressures and vicissitudes which life in a social milieu entails.

Psychiatry is familiar enough with the schizophrenic problem to reach a correct diagnosis from a careful history or through the use of such tests as the Rorshach. Borderline cases, however, are more difficult to diagnose, although easier to treat. In the next chapter we will study the dynamics of the schizoid character structure as it is revealed in the analyst's office.

* *The Winston Dictionary (College Edition)*. New York, Collier & Son, 1943.

The Language of the Body
Alexander Lowen

17

The Schizoid Character

I SUGGESTED IN THE PRECEDING CHAPTER THAT THE DISTINCTION between the schizophrenic and the schizoid character structure was one of degree. This is not to say that qualitative differences cannot be found. Certainly, at the extremes, one may hesitate to compare the institutionalized schizophrenic with the well functioning schizoid character. Yet basic similarities in the underlying dynamic processes of the personality structure compel the comparison for both theoretical and therapeutic reasons.

If an individual has never made an acute break with reality are we justified in describing the structure as schizoid? Such a diagnosis depends upon tendencies and not events. One hesitates to act on this basis in internal medicine. Few physicians will diagnose a patient as a potential cardiac if no structural damage can be proved. But one risks the attack which can and has happened as the patient leaves the doctor's office. If tendencies can be clearly established as criteria for diagnosis, preventive medicine will be greatly advanced. Depth analysis, either psychologically or bioenergetically, offers such a means to this end.

Fenichel (1945, p. 443) defines the schizoid problem in different terms: "Persons who without having a true psychosis yet show single traits or mechanisms of a schizophrenic type have been designated "'schizoid' or 'schizophreniainitis' or 'ambulatory schizophrenia' or the like." Such individuals will show evidence of pathogenic mechanisms of a neurotic kind and of a psychotic kind. Then Fenichel adds a remark which is dynamically important. "Circumstances will decide whether the psychotic disposition will be provoked further or soothed." It is just this presence of a "psychotic disposition" as opposed to psychotic behavior which distinguishes the schizoid character from the schizophrenic. But what exactly is this "psychotic disposition"? While it may be helpful to point to "single traits" or "mechanisms" as evidence of such a disposition, it is fundamentally dangerous to base a diagnosis

upon their presence or absence. One may recall the case presented in Chapter 10 on masochism in which the patient described a real hallucination; the vision of a face which he called "the devil." I had no hesitation in classifying the character structure as masochistic and not schizoid. He lacked a "psychotic disposition." On the other hand, I have seen cases in which this basic disposition could be discerned without a manifest single psychotic trait or mechanism.

All authors are agreed that in the schizoid character there is an important affective disturbance. Fenichel (1945, p. 445) specifically states that, "The emotions of these persons generally appear to be inadequate. . . . They behave 'as if' they had feeling relations with people." While such statements are basically true, it is difficult to use them as distinguishing characteristics. Neurotics show inadequate emotional responses, exhibit an "as if" behavior and use mechanisms of "pseudo contact" in their relations to other people. But I, too, am forced to say that the aggression of the schizoid is an "as if" aggression, it is "put on" as a matter of survival and bears the same relation to the personality as clothes. One senses that it is not an integral part of the real being.

The psychotic disposition must first be understood in terms of ego psychology. Let us compare it with the other character types. The rigid character structure is dominantly aggressive, determined and insensitive. His attitude may be characterized by the expression, "I will." Now, the will may be weak or strong depending on the physical strength and vitality of the body. The strength of the "I" or ego depends on the freedom from pregenital drives which may be intermixed in the structure. We have thus a quantitative factor and a qualitative factor. The masochistic structure is doubtful, hesitant and ambivalent. His basic attitude is reflected in the expression, "I won't," although on the surface he may make every effort to be positive. He invariably fails. The aggression of the masochist is turned inward, it is self-destructive. Regardless of the physical strength of the masochist, his "I" (ego) is weaker than that of the rigid character. His genital function is less secure and his attitude towards reality vacillates. The oral character has a weak aggressive drive. His attitude may be subsumed as an "I can't." This inability to cope with the demands of reality leads him to reject them. He carries a deep resentment against the injustice and unfairness of the social system. His ego is weak, for it is still tied to his oral needs and sense of deprivation, but it is real. The oral character identifies strongly with this ego attitude for he feels it to be the basis of his personality. To give it up is to lose his identity as he has always known it.

Now what of the ego structure in the schizoid personality? It shows none of these basic attitudes and all of them. Sometimes the schizoid acts with strong determination, but it doesn't last. The aggression doesn't collapse into a morass feeling it disappears. When it surges there is a feeling of omnipotence because it has not been tested by reality. The function of reality testing is relatively undeveloped. This omnipotence of aggression differs from the inflated ego and elation of the oral character in that it is a true material drive. It is experienced as a power to do things and not as a power of thought. Where the oral character cannot accomplish anything with his inflated ego, the schizoid may and can be constructively creative. The very lack of ego restraint may make possible a breakthrough of the barriers of reality as they are ordinarily known into new ways of feeling and acting. We owe much to just such achievements by artists like Van Gogh, Gaugin and others. It is a will without an "I".

Ingrained characterological attitudes of "I won't" and "I can't" are missing from the schizoid personality. Since his basic attitude derives from a denial of the values of material reality he has no need to fight this reality. On the surface, though, one may find masochistic attitudes and oral tendencies which derive from specific experiences in his life history. These, however, are not related to the ego. They do not manifest themselves in the transference situation and are not found as deep resistances. In fact it is characteristic of the schizoid that he has few if any real ego defense mechanisms. For this reason, too, once a good contact has been established with him, the therapy may advance at a surprising rate. This explains Fenichel's (1945, p. 451) observation that, "Sometimes schizoid personalities react more favorably to analysis than one expects."

The schizoid character functions in reality as a matter of survival but without the inner conviction that its values are real. He lacks the control over his reactions which the neurotic has, neurotic though that control may be. He is more at the mercy of external forces than the neurotic. He responds to affection immediately and directly but just as immediately will he freeze in a situation which he feels is negative.

Where the schizophrenic in his break with reality completely loses his ego, the schizoid character can avoid the break and retain his ego. But it is a weak ego, weaker than the ego of the oral character. It is not that the schizoid character doesn't feel himself, he does. It is his feeling of himself in relation to material reality that is weak. On the other hand, his capacity for spiritual feeling, for tenderness, for sympathy is great. The schizoid perceives himself as a spiritual person, full of deep feeling, tenderness, sympathy, etc. Unfortunately, it is difficult for him to focus this upon an object in the material world; his lack of ego identification with and control over his motor coordination is an obstacle. Actually, the schizoid character can focus tender feelings upon another individual briefly. The tension created by the attempt to maintain contact forces a break. The concept of motor coordination must be understood as describing movement which is integrated with appropriate feeling. Dissociated movement is possible; the schizoid character may be an excellent ballet dancer. Dissociated feeling is typical, expressive movement is difficult. The tendency to instinctual defusion, to the dissociation of movement and feeling is characteristic of this condition.

Where the schizophrenic in his break with reality will suffer from depersonalization, the schizoid character maintains the body-mind unity by a tenuous thread. He uses his body as I use my automobile. He has no feeling that he is his body, but rather that the body is the abode of his feeling and thinking self. This is not infantile for it in no way reflects the infant's identification with bodily pleasure. The body of an individual is his most immediate reality as it is also the bridge which connects his inner reality with the materal reality of the outer world. Here, then, we have the key to the therapeutic treatment of the schizoid personality. First, to

bring about some identification with or to increase an identification with kinaesthetic body sensation. Second, to increase the depth and range of expressive movement. Third, to develop the body relationship to objects: food, love object, work objects, clothes, etc. The effect of this approach is to strengthen and develop the ego which, as Freud reminds us, "is first and foremost a body ego."

Let us study the dynamics of the body structure as we see it in schizoid characters. Frequently we are first impressed by the appearance of the head. It never looks as if it were firmly attached to the neck. Not uncommonly it is held at a slight angle in such a way that one feels it could roll to either side. Other character types sometimes carry the head inclined to one side in an expression of hopelessness. In these cases, the total body structure has the same expression. The schizoid or schizophrenic attitude is one of detachment, as if the head were pulled out of the main line of energy flow in the body.

Palpation of the neck muscles in the schizoid individual reveals strong isolated tensions but no generalized rigidity. The deep tension at the base of the skull is significant. The head itself is contracted and tight which may give the whole head a gaunt expression. Outside of this expression, the face is commonly masklike. The scalp across the top of the head is tight and there is a strong tendency to frontal baldness in the male. We have mentioned the flatness of the forehead and the lack of expression in the eyes. The mouth is never full or sensuous. After a time one is struck by the continued absence of joy, fullness or brightness in the expression. It is not gloomy, it is cold.

The shoulder segment in the schizoid character shows a characteristic disturbance. The arms have power but the movement of hitting is split. The body does not take part in the action. This is a different quality than the disturbance found in the oral character. There the arms appear disjointed and one senses that the evident muscular weakness is the responsible factor. In the oral character, the movement looks impotent; in the schizoid character it looks mechanical. The best way to describe the motion is to say that the arms move on a stiff, non-participating body which makes one think of them as the arms of a windmill. Regardless of the amount of physical

strength in the schizoid, this quality cannot be missed. Masochistic movements are characterized by the sense of effort, but not of will. The very nature of the shoulder block is different. In the masochist, the shoulders have a muscle-bound look. The deltoid, trapezius and superficial muscles are overdeveloped. In the schizoid character structure, the muscle tensions are deep and based upon the immobility of the scapula.

I mentioned the quality of the neck tensions. The spasticity deep at the base of the skull is reflected in a corresponding block in the small of the back at the junction of pelvis and spine. This tension is so severe in some schizoid individuals that it may produce acute pain. It differs from the chronic low backache found in the rigid structures. The legs show the same relation to the pelvis that the arms do to the shoulder girdle, that is, there is no freedom at the hip joint. The result is an immobility of the pelvis which is more severe than that seen in any neurotic structure. The muscles of the thighs and legs may be flabby or markedly overdeveloped. In either case, one notes a lack of contact with the legs and with the ground. The feet are invariably weak especially the metatarsal arch. The joints are stiff and immovable and this is most clearly evident in the ankles. I have never seen a schizoid structure in which the ankle joint was flexible; it seems as if the joints are frozen. The importance of this will be evident later.

Fenichel (1945, p. 446) describes two characteristic muscular attitudes. "Usually an extreme internal tenseness makes itself felt by hypermotility or hypertonic rigidity behind an external mask of quietness; at other times the opposite takes place—an extreme hypotonic apathy." The former is a state of hypermotility dissociated from any emotional content. The body is tense and charged but movement is mechanical. In the second case, motility is reduced, but there is less affective dissociation. The hypotonicity is limited to the superficial muscles. Palpation always confirms that the deep muscles are spastic. Two female patients who had a schizoid character structure reported that they tended to retain fluid when they became somewhat apathetic. One patient said that she gained up to sixteen pounds by fluid retention. The increased

motility induced by the bioenergetic therapy overcame this tendency.

We noted the observation that the respiration of the schizoid character and of the schizophrenic shows a characteristic disturbance. Reich described the low air intake in spite of the soft chest and seeming large excursion of the rib cage. There is another factor involved in this paradox. In the schizoid structure the expansion of the chest cavity is accompanied by a contraction of the abdominal cavity. This prevents the diaphragm from descending or we may say that the diaphragm also contracts so that the downward movement of the lungs cannot occur. Under such a condition, the schizoid or schizophrenic makes an effort to breathe in the upper part of his chest in order to get sufficient air.

Further observation of the respiratory movements made me aware that the diaphragm is relatively immobile; it is frozen in a contracted condition. The lower ribs flare outward. Since the diaphragm is inactive, a strong expansion of the chest cavity tends to pull the diaphragm upward by suction. This same suction seems responsible for the collapse of the belly. One observes that the belly is sucked in during inspiration then pushed out during expiration. This is not the normal type of respiration. In the average individual chest and belly tend to make the same movement. This unity of the respiratory movement, one in which the wall of the thorax and abdomen move as one piece, is very evident in animals and children.

This kind of schizophrenic respiration has an emotional sign. If you duplicate it in yourself (inflate your chest and pull in your belly), you will hear a gasp as air enters your lungs. It is not difficult to recognize this as an expression of fright. The schizophrenic breathes as if he were in a state of terror. Occasionally this terror can be discerned in the expression of the eyes and face.

One immediate result of the immobility of the diaphragm is a division of the body into two halves, upper and lower. This is not a reflection of the antithetical relationship of ego and sexuality based upon the pendular energy swing which maintains the basic unity. The schizophrenic split represents the collapse and dissocia-

tion of the ego and of sexuality. The sexual behavior of the psychotic in the institution and of the schizophrenic outside may be regarded as an attempt to maintain or establish some function in reality. The use of sex as a means to establish contact with another human characterizes the sexual behavior of the schizoid character.

We can explain all these observations by the bioenergetic concept of lack of unity in the body structure. The various segments of the body are functionally split off from each other. But this is a quantitative phenomenon. In the severe case, the chronic schizophrenic, this splitting of the body structure is clearly evident from their figure drawings and in their body image (See Fig. 18.) The schizoid character shows the splitting only as a tendency. Machover (1949, pp. 62, 75, 137) has observed this phenomenon in her study of the drawings of the human figure. "Schizophrenic or extremely depressed subjects may omit the arms as indication of positive withdrawal from people and things." Here is how Machover interprets another schizophrenic drawing. "The broken line further permits a fluidity of environmental exchange with an unintegrated and insecure body image. It would allow for the escape and evaporation of body impulses, while not offering protection against the hazards of the environment." Again, she shows good insight into the problem in this observation. "Individuals who indicate the joints may be suspected of a faulty and uncertain sense of body integrity. . . . The schizoid, the frankly schizophrenic individual . . . will lean on joint emphasis to stave off feelings of body disorganization."

Figure drawings will inform us how the subject perceives his own body. It may astonish some to realize that each individual, neurotic or psychotic, perceives it as it is; that is, the body image reflects the functional body. Since function is also expressed in structure and movement, we can use body structure and movement as diagnostic tools and therapeutic agents. In bioenergetic analysis, the interpretation is made from the body itself rather than from the drawing.

The major segmentations in the schizoid and schizophrenic structures are the separation of the head from the body, the splitting of the body in two at the diaphragm, the disunity of trunk and pelvis and the dissociation of the extremities. The separation of the head from the body is the bioenergetic basis for the split

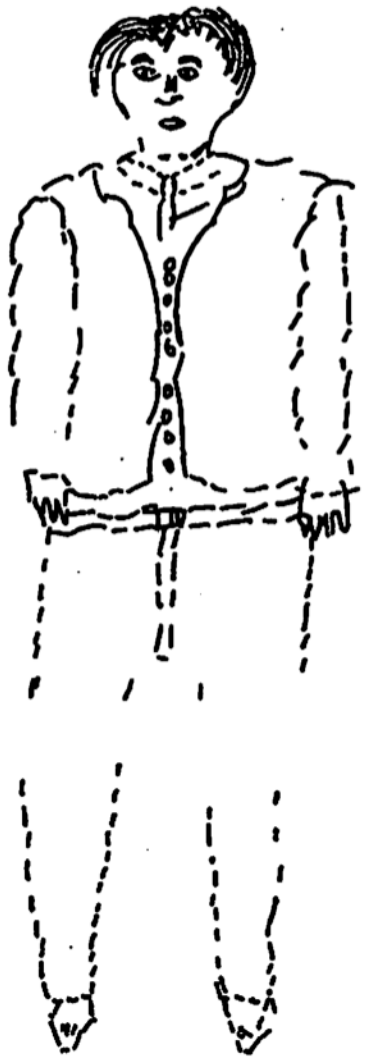

FIG. 18. Schizophrenic drawing of the human figure. Note the accentuation of the head, the dissociation of the hands from the forearms and the broken outline of the body contour. From Machover, Karen, *Personality Projection in the Drawing of the Human Figure*, 1949. Courtesy of Charles C Thomas, Springfield, Ill.

between perception and excitation. The similar separation in the lower half between pelvis and trunk implies a dissociation of the genital sensation from the total body feeling. In addition, the head, the pelvis and the extremities are contracted and undercharged which I would interpret not as a withdrawal from reality but as a failure in development.

In contrast to this picture, the neurotic structure shows a definite unity. In the oral character this unity is manifest in the withdrawal upward from the earth. This is very clear in the tall, asthenic individual. We can deduce it from the fact that the energy in the oral character tends to flow upward, overcharging the head at the expense of the lower part of the body. We find a dominance of those activities which may be interpreted as oral. The masochistic structure is typically muscle bound. Frequently the body structure is short and heavy with considerable muscular strength. The whole body seems to be holding in or holding back. The masochist struggles continuously against this total holding. The rigid structures, to the extent of their rigidity, move as one piece. There is no question of their unity. We can say of the schizoid body structure that it is held together loosely as if by the skin. Movements look mechanical. One has the impression that they are consciously willed. Typical gestures which stamp an individual are absent.

Where the eyes of the schizophrenic have the "far away" look which indicates a lack of contact with reality, the eyes of the schizoid patient seek the eyes of the therapist. One is struck by this desire for contact as if it were the dominating principle of their personality. While the voice is generally flat, the words may be clearly enunciated, and this also gives one the feeling of an effort being made. I recall another schizoid patient whose history was one of immense effort against terrible handicaps. In her early therapy, many of the movements were too strong for her. She became confused and frightened. I asked her to stop but she said, "I can take it." In no other type of character structure have I found such sincere effort to overcome problems.

We are in a position now to venture an hypothesis on the etiology of schizophrenia and of the schizoid character structure. We are forced necessarily to proceed inferentially from known bioenergetic

principles, but we can confirm our ideas with clinical data and by the observation of infants.

We must begin with the assumption that at conception the organism is a unity. This means that we eliminate heredity as an important factor in the etiology of emotional illness. It may or may not play a role in determining the predisposition to functional pathology, but we must be cognizant of the fact that the importance of heredity as a factor in disease processes is constantly being reduced with the advance of medical knowledge. In previous chapters we studied the main neurotic disturbances in the emotional life of the individual and we elucidated many of the responsible factors. Not one of them nor all of them could produce the psychotic condition without the operation of a different kind of traumatic experience. So far as I know there is only one experience which is so traumatic that it could split the unit of the growing organism. The operative agent could only be described as the hatred of the mother for the child, a hatred which is mostly on the unconscious level.

One must understand the bioenergetic nature of hatred in order to comprehend its etiological role in this disturbance. First, however, let me point up the difference between this factor and those operative in the neuroses. The oral character develops in response to inner feelings of deprivation. The masochistic structure is formed in the process of suppression by a mother who is overprotective and oversolicitous of the child. Rigidity is a product of frustration, and development of the oedipal period. Is it possible that these children have not experienced any hatred from their parents? It is highly unlikely. If one observes the behavior of parents in the various crises which beset them, one will see and hear many expressions of hatred directed towards their children. But these are conscious reactions which pass with the situation. The damaging hatred is unconscious, deep-seated and persistent. It is operative in the very earliest history of the organism.

In ascertaining the nature of hatred we should begin by making an important distinction. Hatred and anger are not the same thing. Anger is a hot feeling which has as its object the removal of an obstacle to the flow of libido. Hatred is cold and unmoving. While

anger may be destructive in its manifest action, its aim is basically constructive. Anger does not aim to destroy the object of libidinal attachment, hatred does. Anger is the flood of aggression unmixed with any tender feelings. Yet as soon as the flood recedes, the feelings of tenderness flow again. Anger is the thunderstorm on a summer day which is followed by the sunshine. Hatred may be compared with the unremitting cold and bleakness of a frozen wasteland. Freud pointed out that hatred is related antithetically to love. We all know that one can turn into the other. But how?

To understand a relationship we must define all terms in it. Can we define hate? It might be easier to attempt to define love. This is not so difficult in bioenergetic terms for the basic ingredients are known. We saw that the fundamental instincts were feelings of tenderness and movements of aggression. Love in the strictest sense can be described as the deepest feeling of tenderness expressed with the strongest aggression. Such a statement implies that it is the fullest expression of an organism. We can identify the deepest feeling of tenderness as one that stems directly from the heart and in which the heart is fully involved. The strongest aggressive action involves the total body musculature and expresses in action the full intensity of the heart feeling. It is obvious that such a strict definition does not fit all the manifestations which are described as love. The definition can be extended, then, as we wish, to include expressions in which the heart feelings are appropriately expressed in aggressive action although the intensity of the feeling and the strength of the aggression vary. Let us study some specific cases.

The love of a mother for the nursing infant is heartfelt and deep. Yet while the intensity of the tender feelings is at a maximum, the aggression is considerably reduced. At most it involves the upper half of the woman's body with emphasis upon the action of the mammary glands. We mentioned earlier that tender feelings which do not involve the aggressive tendencies can be described as sympathy, pity, etc. For that reason, those who need the physical warmth of body contact reject these feelings. If no tenderness is involved in the physical action its emotional quality can be described as sadism. Many women sense the sadism in

an act of intercourse which lacks a tender feeling. Love, in every one of its expressions, seeks the union of two organisms on both the spiritual and physical levels. In the sexual act which is an expression of love the most complete union and identity of two organisms is possible.

What about hatred? Hate is frozen love. This explains why, as love cools, there is always the danger that it may turn into hate. On the other hand it is also possible that hate can be thawed out again into love. The mechanism whereby this freezing takes place is complicated. Two factors are involved in the process which depends upon a special predisposition. That special predisposition is a rigid structure, the two factors are cold and pressure.

In hate, the heart is cold and hard, the tender feelings are turned to ice. For this to happen, tremendous pressure must be exerted, the process being analogous to that whereby air is converted into a liquid. The pressure is exerted by the individual whose love is rejected. We noted in Chapters 12 and 13 on the hysterical character structure that the child who is frustrated on the genital level stiffens up and becomes rigid. Among adults we describe such an individual as proud, for pathological pride is expressed by a stiff neck and back. In effect this pride says, "I shall not love you, then you cannot hurt me." Once this pattern of stiffening up in response to frustration is established it becomes a set pattern of response which is operative in later life.

Only a rigid character can become truly hateful. The oral character lacks the muscular development and aggression to confine his tender feelings. His need is too great. The suffering of the masochist prevents his freezing up. Hate is frequently the end result of a severe frustration in later life, generally the culmination of a loveless marriage in which the rigid partner is caught by his own rigidity and inability to move. Unable to seek a new love object, the hurt spouse reacts to the partner's cold by stiffening and becoming more rigid until finally the heart is frozen. This is a picture of the hateful person: cold skin, hard and cold eyes, rigidity of the body, cold hands which hurt rather than caress, and a manner which is impersonal, cold, compulsive and tight. Now what is the effect of this hate upon the sensitive, dependent infant?

The child of a hateful woman is subjected to this cold long before it is born. If the heart is cold and hard, what can we expect of the womb?* The embryo growing and developing in a cold, hard womb will also freeze but in a way that is different from the freezing which takes place at an adult age. In the womb the freezing is due solely to the cold and not to the pressure. The embryo is also much more highly charged energetically than the adult and its energy resists the freeze much better than the energy system of the rigid adult.

The process of this freezing may be compared to what happens to a water solution of brown sugar when it is gradually frozen. After a time one notes that the brown color is concentrated in the center while the periphery of the solution is clear ice. The center retains its fluidity to the last since the cold penetrates from the outside inward. There is produced in this fashion a partial separation of the solute and the solvent. Quick freezing or freezing under pressure would trap the ions or molecules of the solute in the frozen solvent and immobilize them. This observation can be repeated with other colored solutions.

In the embryo within a cold, unloving womb, a similar separation occurs. The free energy of the organism withdraws to the center while the peripheral system is frozen; that is, the core is alive but the structural elements close to the surface become frozen. Without this analogy one cannot explain the tendency to complete defusion which is characteristic of schizophrenia. What is frozen, then, is the physical motility of the organism. I do not mean to say that the foetus is turned into a block of ice. The freezing process is not so intense as to destroy life. Actually, its effect is most intense at the natural constrictions of the body, those areas which do not contain big organs which have quite a strong independent charge. One should expect to find the frozen condition most evident in the neck and waist and at the joints. These are the places where schizophrenic and schizoid structures show the greatest disturbance of motility. This is not schizophrenia. It is, however, the indispensable predisposition to this illness.

* Cf. Wilhelm Reich in *Character Analysis*, ed. 3. New York, Orgone Institute Press, 1949, p. 447.

Postnatal life may provide a sufficiently warm environment to thaw the frozen areas. However, since it is unlikely that the birth of the child will in itself transform the mother, the newborn infant is projected into an environment which is frequently more openly hostile than the one it experienced in the protected state of the womb. The danger now becomes more evident. It becomes the gradual experience of the infant and the child that reality, experienced as the cold and hateful mother, poses a threat to life. On no other basis can we understand the utter terror, the fear of persecution and of physical violence and death which torment the schizophrenic.

These remarks are not intended as a condemnation of the mothers of schizophrenic patients. Our sympathy must extend to them as victims of a disturbance which in its own way is more severe than that experienced by their unfortunate offspring. One recalls again Dostoevsky's remark that "Hell is the suffering of those unable to love." Their unconscious sense of guilt in later life is pitiable.

One of the best books on the psychoanalytic therapy of schizophrenia is L. B. Hill's *Psychotherapeutic Intervention in Schizophrenia*. In this valuable work, he discusses the mothers of schizophrenics in a warm personal way. Hill (1955, pp. 109, 112, 121) admits that many psychiatrists regard the mothers of schizophrenics as "utterly hostile, malicious, and in every way a misfortune," but he feels that this is not completely true. Hill regards these mothers as ambivalent. But this is not the ambivalence of to love or not to love. It is the ambivalence of to love or to hate. From the surface appearance they may want to love this child and they may try, but an underlying hate prevails. Witness this remark, "Psychiatrists interviewing the mothers of schizophrenic patients have reported feeling much as a schizophrenic seems to feel—that mother is superficially optmistic, cooperative, friendly, and yielding, but that not far beneath the surface she freezes when anything unpleasant is mentioned." Too bad we have no record of the look in her eyes. It is on this occasion that her eyes will show the hatred which froze the infant. One more quote from Hill to show how close good psychoanalytic thinking is to bioenergetic thinking: "The disappointments which these mothers have in reality throw them painfully back into their world of inner objects of love and

hate. The child who is being carried at the time of great stress and who comes from within and has recently been a part of the mother is the natural heir to all of her frustrated object seeking."

There is no theoretical consideration which urges us to place the earliest etiology of the schizophrenic condition in the prenatal period. Deprivation of mother love is not an experience which so far can be identified as occurring prior to the birth of the child. Adults who suffer from this feeling of deprivation show an infantile pattern of behavior. If the trauma is more severe than this it must represent a negative attitude and not the absence of a positive one. Such a negative attitude in the mother must have an adverse effect upon the child she is carrying at the time. This time element is the reason why one child will show this disturbance while his siblings may be free from it.

If, in this discussion, I have oversimplified the problem my intention to do so was deliberate. I have desired to make a point from which more detailed studies and investigation can be undertaken.

We saw the effect of hate upon the bioenergetic system of the child. How does this translate itself in terms of his emotional development? What are the psychological correlates of this disturbed bioenergetic state?

The schizoid character and certainly the schizophrenic must struggle through life with a vital core of feeling and energy but with a crippled and bound motor system for discharge. Since he can rely very little upon his motor system, he depends upon his heightened sensitivity to avoid danger and achieve success in the material world. This is of course inadequate so that his frustration increases the sense of conflict. Basically the conflict is what to do with his aggressive tendencies. For, like in all conditions of traumatic injury, there is an unconscious struggle to restore the lost unity. What prevents this?

Difficult as is the adult world of reality in which the schizoid or schizophrenic finds himself, it is a world of physical warmth as compared to the environment of his infancy and childhood. But while this warmth offers promise it also poses danger. The thaw may produce a flood which will overflow the banks. The

flood of aggression, dissociated from tender feelings, could only lead to one thing: murder, the destruction of the object who threatened and hurt him, the smashing of all reality. Hill (1955, p. 151) put it well when he wrote, "for the schizophrenic to gain that independence from his infantile superego which is one of the goals of psychoanalysis is in his feeling fully equivalent to his murder of his mother."

We come to the conclusion then that the schizophrenic hates his mother unconsciously. But he is not a cold, hateful person. His hate does not involve his heart, only his muscles. It was not his heart that froze, only his muscular system. But this poses a real problem for the bioenergetic therapist since any attempt to thaw out the frozen state must be made very gradually and under control. The schizophrenic is so much afraid of his hatred that he will resist any attempt to mobilize his aggression. Once this fear is broken through great progress can be made. Rosen (1953, p. 150) understands this so well intuitively that he will take up the challenge of the patient's aggression directed against himself. "The aim of therapy is to direct this aggression toward the therapist rather than to have the patient dissipate it amorphously in his usual schizophrenic fashion." This may lead to an actual physical struggle with the patient in which the physician can prove that physical aggression can be controlled to constructive ends.

This latent hatred of the schizophrenic for his mother is the bond that ties him to her just as her latent hatred binds her to the patient. Hatred not only freezes the individual motility, it also freezes the relationship. It is as if the schizophrenic and his mother were frozen together in a mutual bond of hatred and repugnance.

The schizoid character, in contrast to the schizophrenic, has much greater motility and coordination, a better organized ego and a measure of independence. In his treatment we can count on a greater conscious participation. Nevertheless, the basic schizophrenic tendencies are present and the therapy must be oriented along the same line as if one were treating a schizophrenic.

The schizophrenic and the schizoid character have no ego defenses. Now this will be a tremendous positive factor in their therapy for they cannot and do not unconsciously resist. Not that

resistance is a conscious phenomenon. The schizoid character is unaware of any real resistance, but it will take the form of distrust, of fear of the therapist, of fear of the therapy. He is aware of this. These are patients who have no defense in depth and so must be on guard. As against this kind of resistance the therapist can only offer his sincere effort, his humility and his honesty.

As part of this lack of ego defense, the schizophrenic and the schizoid character have great sensitivity—especially about people upon whom they feel dependent. It has been said by others that they respond directly to the unconscious and I would subscribe to this statement. They can see through the therapist as quickly as any therapist can see into them. And who of us is free from his neurotic problem? To help them, then, one must know one's self well, especially his limitations and weaknesses. Since we cannot offer our schizophrenic or schizoid patient a perfect human being, we must make no pretense of doing so. We offer reality, the reality of ourselves which is the sincerity of our effort, the humility of our attitude and the honesty of our conscience.

These are indispensable personal qualities which every therapist working with such patients must have. There is one more thing which is absolutely required. That is warmth. No amount of sincerity, humility or honesty can help a schizophrenic or schizoid patient without the real warmth of the therapist's feeling for the patient. This means that the therapist must be a warm person and that he must really like the patient. The therapist's warmth is the therapeutic agent by means of which he can bring the patient more deeply into reality. Now here is where the lack of ego defense proves its aid. The neurotic will question even a sincere expression of warmth and affection, and only when the neurotic defense is eliminated is it fully accepted. Not so the schizoid or schizophrenic. To the degree that it is freely given is it freely accepted. Despite the magnitude of the problem, it is a great pleasure to work with the schizoid personality. In the course of therapy, as the warmth pervades their being, they will give generously to their therapist.

The schizoid and the schizophrenic demand one more quality in their therapist. They demand that the therapist understand them.

Other patients want this, too, but their neurosis blinds them to its presence or absence. These are isolated individuals who live in a world which differs from ours but which is just as real to them. It must be real to the therapist too. I am not speaking of the world of hallucinations and delusions but the real world of spiritual feelings to which they have access. Further, one must have to some degree at least a sensitivity which parallels theirs. It is for this reason that the schizoid characters fully understand one another. It is also true that one who has overcome this illness or disturbance is, perhaps, the therapist who can make the closest contact with them. If, in addition to the understanding of their spiritual feelings, one also understands their body sensations and can speak intelligently about them, a close and important bond can be established with the patient. It is in this respect that the knowledge of the dynamics of the bioenergetic processes is so important. One schizoid patient told me that she was way ahead of the analysts who worked with her. She had to interpret everything for them. But it is not enough that we be with them in our understanding. We must be ahead of them. In the sphere of aggressive behavior, of material reality, of sexual functioning, the schizoid character is a novice. It is not a matter of repression of attitudes or feelings about this world. It is a world he never fully entered into, which he doesn't know and doesn't trust. It is a world of action in which the tender feelings are fused with an aggressive component.

It is one thing to bring a schizophrenic back to a reality he once knew, it is another to build his ego to function fully and adequately in a world he didn't know. This other world is the world of the body and bioenergetic therapy offers the means of giving the patient immediate experience in this world. This is not to say that this other world cannot be experienced except through bioenergetic therapy. It is experienced in the contact of a good transference relationship and, to some extent, in any physical activity the patient may engage in outside of the therapeutic situation. But how much better it is if this experience can be gained directly and increasingly in the therapeutic session. For the warmth that the patient needs is the heat produced by the energy flow in his own tissues and

masculature. Few patients are more thrilled than when they find their body becoming alive, their extremities warm, their skin pink and rosy.

I recall one patient who in the early part of her therapy became confused, bewildered and frightened when I had her arch her body backward and hold the position. She had to stop after only a few seconds. She began to shake and tremble but she didn't know what she was afraid of. I could point out that she was afraid of the sensation in her back, that she was afraid she would be overwhelmed, or that she might fall apart. All she knew was that she was confused. Yet in repeating the procedure and in having her work with her body steadily, she began to lose the confusion and fear. After a time she told me that she was no longer confused or afraid and that periods of confusion which troubled her outside of therapy had likewise disappeared. She could do more things with her body as she gradually gained control. Then she began to free more energy in herself and to experience pleasure as a bodily sensation in movement. If one knows the difficulties these patients have in coming to tolerate body pleasure, one can appreciate this advance. In all these patients, their ability to experience pleasure as a body sensation is a criterion of their increasing health. In another patient, this experience of energy streaming pleasurably through his body, although on the surface, was one of the finest experiences of his life.

One might ask at this point, in what way do the bioenergetic movements differ from physical exercises or other forms of physical activity? This is a very pertinent question for the therapy of this problem. Many schizoid characters have studied dancing yet it did not solve their basic problem. And, in fact, the whole range of bioenergetic therapy revolves around a limited range of movements. But these are movements or attitudes in which the unity of the body is dynamically stressed. It is only when the total organism partakes in a movement that that movement becomes emotionally expressive. It is precisely because of this inability to move in a unitary way that the schizoid or schizophrenic character is emotionally dull. The neurotic who has this unity, even if characterologically rigid or patterned, is capable of a limited degree of emotional expression.

It is important to the whole question of bioenergetic therapy that the therapist have a thorough knowledge of the dynamics of body movement. In hitting the couch, for example, different individuals will use different parts of the body. Some will strike only with the arms, their backs are not in it. Some will use their backs, but the arms move only as mechanical appendages. Only when an effort is made to involve the whole body in the action is there a concomitant feeling of anger. It is necessary to observe which parts of the body are held back in the action to understand the nature of the block to the release of the appropriate emotion.

Emotional health may be defined in terms of the ability of an individual to involve all of himself in his actions and behavior. It should not be surprising that this implies the equal ability in appropriate situations to restrain actions. On the psychological level this may be interpreted as a statement of the integrity of the ego, one that is not split into a conscious ego and an unconscious superego; one that is not divided by the defusion, partial or complete, of its component instincts. On the physical level this implies the absence of chronic spasticity and tension in the muscular elements of the body. An increased motility provides a greater range of action and permits more flexibility in response to situations.

But we are not unaware of the importance of the body expression as a reflection of its internal qualities. We reserve a physical term to designate this innate virtue—grace, and we extend this term to honor our leaders. Difficult as such a term is to apply, we can nevertheless hold it out as our ideal of physical harmony in motion just as beauty expresses that ideal in form.

To be free of the physical restraints imposed by chronic spasticities, to be liberated from the fetters of unconscious fears—this and this alone would make man capable of that love in which his deepest heart feelings are expressed with his strongest aggression.