I surmise that, in so far as an individual is a whole person intrapsychically, and able to participate wholly in his relatedness with other persons as well as with his nonhuman environment, he does not react to this subject of life's finitude as a separate nucleus of feelings in itself. It constitutes, rather, an ingredient of, or background for, all his life-experiences. In so far as we can dare to keep ourselves open to the recognition of the finitude of our lives, this recognition can make our pleasurable experiences more precious, our despair supportable, our work a matter not of resented drudgery but of wholehearted dedication, and so on. Just as one can be a truly whole person only through facing this harshest aspect of reality, the inevitability of death, so, too, can one become able to live fully, only if one lives in the light of this recognition.

I believe others will find, as I have, that the more one explores this whole subject of the psychological import of life's finitude–its import to human beings, whether schizophrenic or non-schizophrenic–the more one's personal philosophy of life is deepened and enriched. And we know how essential it is, for one who conducts psycho-analysis and psychotherapy, to be deeply sure that life is meaningful and worth while–even a life which at times seems meaningless and which ends, inescapably, in death.

Chapter 18

PHASES OF PATIENT-THERAPIST INTERACTION IN THE PSYCHOTHERAPY OF CHRONIC SCHIZOPHRENIA (1961)[1]

At the end of three years of intensive psychotherapy with chronically schizophrenic patients, I found myself occupied, for a comparatively brief period, with the question whether I should go ahead and devote myself, for an indefinite number of further years–perhaps for the whole remainder of my professional career–primarily to this line of endeavour. I decided in favour of doing this, from a feeling of having found myself, in the course of my personal analysis, in the course of these early years in the crucible of the intensive psychotherapy of schizophrenia, and in the course of my developing marital-family life. The question whether I am a human being, possessed of the feeling capacities which activate human beings, had been affirmatively put to rest, and I felt able now to approach this psychotherapy in a new and workmanlike spirit, sure that the basic potential for this work was there in me, and curious to see what truly professional *techniques*, quite beyond the countertransference-ridden flounderings of the neophyte, I could develop in grappling with this remarkably complex job that clearly needed doing.

The nine years which passed between making this decision and writing this paper, while confirming for me the validity of that shift in my feeling-orientation, have none the less forcibly brought home to me the realization that the 'technique' of psychotherapy of schizophrenia is best spelled out in terms of an evolutionary sequence of specific, and very deep, feeling-involvements in which the therapist as well as the patient becomes caught up, over the course of what has emerged, for me, as–in necessarily broad and schematic terms–the 'normal'

[1] First published in the *British Journal of Medical Psychology*, Vol. 34 (1961), pp. 169-93.

and predictable over-all course of psychotherapy with the chronically schizophrenic person. This paper, then, will attempt both to highlight the crucial role of feelings in the therapeutic relationship, and to delineate what I have found to be this 'normal' over-all pattern of the psychotherapeutic course which that relationship follows over the years of the patient's treatment.

The therapist's feeling-involvement in this therapeutic work is, for various reasons, a deep one, and personal analysis does not spare him from the deep involvement which is so necessary, but rather makes his feelings more available to him for it.

First, the very length of time required for this therapy tends to foster a deep involvement on his part, such that the hours he has spent with the patient over the course of say six or eight or ten years become deeply a part of all that the years have brought for him–the joys and sorrows, the triumphs and bereavements.

Secondly, the various forms of intense transference on the part of the schizophrenic individual tend forcibly to evoke complementary feeling-responses, comparably intense, in the therapist. Mabel Blake Cohen (1952) has made the extremely valuable observation, for psycho-analysis in general, that:

> . . . it seems that the patient applies great pressure to the analyst in a variety of non-verbal ways to behave like the significant adults in the patient's earlier life. It is not merely a matter of the patient's seeing the analyst as like his father, but of his actually manipulating the relationship in such a way as to elicit the same kind of behaviour from the analyst. . . .

It is not too much to say that, in response to the schizophrenic patient's transference, the therapist not only *behaves like* the significant adults in the patient's childhood, but experiences most intimately, within himself, activated by the patient's transference, the very kind of intense and deeply conflictual feelings which were at work, however repressed, in those adults in the past, as well as experiencing, through the mechanisms of projection and introjection in the relationship between himself and the patient, the comparably intense and conflictual emotions which formed the seed-bed of psychosis in the child himself, years ago.

A third reason for the necessarily deep feeling-involvement on the part of the therapist is inherent in the nature of early ego-

formation, the healthy reworking of which is so central to the therapy of schizophrenia. Spitz (1959), in his monograph on the early development of the ego, repeatedly emphasizes that emotion plays a leading role in the formation of what he describes as the 'organizers of the psyche' (which he defines as 'emergent, dominant centres of integration') during the first eighteen months of life. He says, for example, that:

> . . . the road which leads to this integration of isolated functions is built by the infant's object relations, by experiences of an affective nature. Accordingly, the indicator of the organizer of the psyche will be of an affective nature; it is an affective behaviour which clearly precedes development in all other sectors of the personality by several months.

This brings us back to my other main topic, namely the phases comprising the over-all course of psychotherapy with the chronically schizophrenic person. Within recent years I have become increasingly convinced that it is possible to delineate such phases amongst the complex, individualistic, and dynamic events of clinical work. One can take heart, in this difficult effort at conceptualization, from Freud's delineation of the successive phases of libidinal development in healthy maturation, from Erikson's (1956) portrayal of the process of identity formation as a gradual unfolding of the personality through phase-specific psycho-social crises, and from Hartmann's (1956) statement, concerning the process of evolution of the reality principle in healthy development, that 'The impact of all stages of child development–the typical conflicts, the sequence of danger situations, and the ways they are dealt with–can be traced in this process.'

The successive phases which in my experience best characterize the psychotherapy of chronic schizophrenia, with each of which the remainder of this paper will deal in turn, are the 'out-of-contact' phase, the phase of ambivalent symbiosis, the phase of pre-ambivalent symbiosis, the phase of resolution of the symbiosis, and the late phase–that of establishment, and elaboration, of the newly won individuation through selective new identifications and repudiation of outmoded identifications.

The first three of these phases retrace, in reverse, the phases by which the schizophrenic illness was originally formed. To my

way of thinking, the aetiological roots of schizophrenia are formed when the mother-infant symbiosis fails to resolve into individuation of mother and infant–or, still more harmfully, fails even to become at all firmly established–because of deep ambivalence on the part of the mother which hinders the integration and differentiation of the infant's and young child's ego. The child fails then to proceed through the normal developmental phases of symbiosis and subsequent individuation; instead, the core of his personality remains unformed, and ego-fragmentation and dedifferentiation become powerful, though deeply primitive, unconscious defences against the awareness of ambivalence in the object and in himself. Even in normal development, one becomes a separate person only by becoming able to face, and accept ownership of, one's ambivalent feelings of love and hate towards the other person. For the child who eventually goes on to schizophrenia, the ambivalence with which he had to cope in his relationship with his mother was too great, and his ego-formation too greatly impeded, for him to be able to integrate his conflictual feeling-states into an individual identity.

My theoretical concepts have been fostered by Mahler's (1952) paper on autistic and symbiotic infantile psychoses and by Balint's (1953, 1955) writings concerning phenomena of early ego-formation which he encountered in the psycho-analysis of neurotic patients. In 1958 (see chapter 10 above), I ventured to express my conviction that a symbiotic relatedness between patient and therapist constitutes a necessary phase in the transference-evolution of successful therapy with either psychotic or neurotic patients, although it is particularly prominent and important in the former group. I have noticed with great interest, therefore, that Mahler and Furer (1960) emphasize that 'Our first therapeutic endeavour in both types of infantile psychosis [i.e. both autistic and symbiotic] is to engage the child in a "corrective symbiotic experience". . . .' Loewald (1960*a*), too, reports that what I call a symbiotic relatedness occurs in the schizophrenic patient's transference to the therapist: as he puts it, '. . . If ego and objects are not clearly differentiated, if ego boundaries and object boundaries are not clearly established, the character of transference also is different, in as much as ego and objects are still largely merged. . . .'

It is now time to embark upon a description of the successive phases of therapy with the chronically schizophrenic adult patient.

The 'Out-of-contact' Phase

I do not term this the 'autistic phase', for the reason that the word 'autistic' has come to have a certain connotation, in psychodynamic theory, which I regard as invalid and therefore do not advocate. Specifically, the term 'autistic', as generally used, conjures up Freud's (1911) psychodynamic formulation of schizophrenia as involving withdrawal of libido from the outer world and its subsequent investment in the self–as involving, in other words, a regression to narcissism. My own view is that there occurs instead, in schizophrenia, a regressive dedifferentiation towards an early level of ego-development which has its prototype in the experience of the young infant for whom inner and outer worlds have not yet become clearly distinguishable as such (see chapter 16). This is in line with the formulations of Werner (1940), and Loewald (1960*a*) follows the same reasoning in his previously mentioned paper.

To the degree that the patient is schizophrenic, this phase predominates during the early months, and in many instances the early years, of his therapy. Characteristic of this phase is the circumstance that his feelings are unavailable to himself and are not conveyed in his interpersonal relationships; hence the therapist experiences comparatively little in the way of feeling responses to the patient's behaviour, except for a sense of strangeness, of alienness, in reaction to the bizarre symptomatology into which the patient's feeling-potentialities have long ago become condensed–the hallucinations, the delusional and neologistic utterances, the stereotyped and manneristic non-verbal behaviour, and so on. It is seldom that the therapist feels that the patient even perceives him, undistortedly enough for the therapist to sense that he as a person in the here and now is being seen, or heard, or otherwise perceived, by the patient who much more often shows, instead, every evidence of being lost in a world of chaotically disturbed and distorted perceptions. Patient and therapist, so long as this phase endures, have clearly not yet entered into a deep feeling-relatedness with one another.

The feeling-orientation in the therapist which best serves a

constructive approach to the patient and his bizarre symptomatology, and best facilitates the traversing and resolution of this phase of the therapy, is a calm, neutral, investigative orientation. By contrast, the inexperienced therapist is apt to approach the patient in a spirit of urgent need to relieve the suffering of this deeply and tragically ill person. One is helped to relinquish such an attitude, which to the extent that it predominates renders constructive therapy impossible, by realizing a number of things about the patient. First, as Szalita-Pemow (Personal communication, 1952) helped me to see, the patient's individuality, his sense of personal identity, resides largely in his psychotic symptoms; thus the therapist is reacted to as threatening to rob him of his individuality, by 'curing' him of his illness. He has no conception of psychological health in our experience of this term; for him, 'getting well' is tantamount to a restoration of the state—the anxiety-ridden, unendurably boring, or what not, state—which he experienced just before he originally became overwhelmed by the psychosis. Basically, 'getting well' is, for him, tantamount to loss of his individuality through return to symbiotic relatedness, towards which he is constantly being impelled by the inner drive which never ceases to pull him back towards the world of people. Also, for him, 'facing reality' is a very different thing from the therapist's being able to face the reality of *his* life; the reality of the patient's own life, which must eventually be confronted if he is ever to become well, is a reality overfull of tragedy and loss.

We need to realize, in the same vein, that the patient is not solely a broken, inert victim of the hostility of persons in his past life. His hebephrenic apathy or his catatonic immobility, for example, represent for one thing an intensely active striving towards unconscious, regressive goals, as Greenson (1949, 1953) has helped to make clear in his papers on boredom and apathy in neurotic patients. The patient is, in other words, no inert vehicle which needs to be energized by the therapist; rather, an abundance of energy is locked up in him, pressing ceaselessly to be freed, and a hoveringly 'helpful' orientation on the part of the therapist would only get in the way. We must realize that the patient has made, and is continually making, a contribution to his own illness, however unwittingly, and however obscure the nature of this contribution may long remain.

It is particularly when the therapist sees the dimensions of the patient's hostility, of his sadism, that he realizes that, on balance, the sufferer is doing what, on the whole, he *wants* to do at the moment. When this understanding comes home to the therapist, he does not need to struggle to maintain some artificially neutral-screen façade, but comes to *feel* on the whole neutral towards the patient whom he sees to be both loving and hateful, and whom, he increasingly realizes, he himself is capable of both loving and hating.

The therapist's hand can be strengthened, in effecting this change, by his identifying with his predecessors who have reported in the literature their achievement of such an attitude towards their work. Winnicott (1947), for example, points out how inevitably hatred is a component of the therapist's, as well as the normal mother's, feelings towards the patient or the child, respectively. Knight (1940) describes his having found that, in the psychotherapy of paranoid patients, the use of such time-honoured techniques as reassurance, re-education, and tactfulness in dealing with the patient's homosexual wishes only causes him to become increasingly paranoid because, Knight saw, the patient has real hatred, and this is what the anxiety is mainly about. Heimann (1955) finds it best not to try to convince the paranoid patient of one's good will, or to avoid coming to terms with his delusional material, and clearly sees the sadism involved in her patient's suffering. Hayward and Taylor (1956) find that 'When a patient is suffering, the decision as to whether to give comfort or to attack is often very difficult', and Hayward's recovered schizophrenic patient tells him, in retrospect, 'You should never have stood by and let me torture you by crucifying myself and making you watch my suffering. You should have forced me to come down or at least thrown rocks at me,' and reminds him that 'People need practice in hating without guilt or fear, just as much as loving'.

The therapist, operating from this basic feeling-orientation, can meet usefully a wide variety of typical problem-situations; I can mention only a few. In response to the patient's manifestation of delusional thinking, he will be aware that, for the patient, the delusions represent years of arduous and subjectively constructive thought, and are therefore most deeply cherished. He will not forget that obscured in them is an indeed indispensable

nucleus of reality-perception. He will not become caught up in either disagreeing or agreeing with the delusional view, but will try to help the patient explore the feelings which this delusional world-view causes him to feel–the dismay, the shock, the despair, and fear, and so on. Not only here, but in general, free from any absorbingly urgent need of his own to 'cure' the patient, he will remain attentive to what the *patient* is experiencing. He will couch his remarks in terms of the patient's own presumed point of view, and when the patient is able to express a feeling–whether of fear or loneliness or anger or what not–the therapist will usually content himself with simply acknowledging the feeling and encouraging its further elaboration, rather than rushing verbosely somehow to relieve the patient of it. Likewise, when a patient is having vigorously to disavow any feeling about a clearly affect-laden matter, the therapist will remain in tune with the patient's own feeling experience, by remarking, 'I gather you don't find yourself having any particular feeling about this',–or, better, will make no mention of feelings–rather than try to overcome the unconscious denial by asserting; 'But surely this *must* make you very angry (or hurt, or what not)'. Similarly, in responding to the expressions of an archaic, harsh superego in the patient, rather than set himself up as the spokesman, the personification, of the repressed id-impulses, he will realize that it is in the superego that the patient's conscious self–his personal identity–mainly resides; thus he will seldom urge the patient to recognize sexual or aggressive feelings within, and will more often acknowledge how strong a sense of protest or outrage the patient feels upon perceiving these in others.

To the extent that the therapist is free from a compulsion to rescue the suffering patient, he can remain sufficiently extricated from that suffering to be able to note significant sequences in the appearance of such symptoms as hallucinations, verbalized delusions, and so forth, and thus be in a position to be genuinely helpful. Even when on a car ride with a patient, or grappling with the latter's physical assault, the therapist may on occasion be able to allow himself enough detachment to help the patient to link up this immediate experience, clarifyingly, with forgotten situations from earlier life; such 'action interpretations' may be especially important to the patient whose memory, and whose capacity for abstract thinking, are severely impaired.

In working with the patient during weeks or months of silence on the latter's part, he will not, out of a compulsion to help the tragic victim of schizophrenia, rack his brain with diligent therapeutic efforts focused upon the patient, who is already afflicted with overwhelming intrapsychic pressures. Rather, the therapist will feel free to let his thoughts roam where they will, leaf through magazines, do some serious reading of current interest to him, and otherwise see to his own personal comfort and freedom from anxiety. This may at times involve periodic letting off of steam at the inarticulate patient; but such blasts do, in my experience, the patient no harm and help one to become again, for a relatively long period, genuinely accepting of this difficult situation. Thus one places in the long run a minimum of pressure on the patient who is already paralysed with pressure, and keeps oneself in a comparatively unanxious and receptive state which, better than anything else, helps eventually to relieve the patient's anxiety and unlock his tongue. Sooner or later, like a bright dawn pushing back a long night, the patient will put his rusty vocalization capacities to work in venting reproach, contempt, and fury upon the therapist for doing, as the patient sees it, nothing to help him.

In general, while aware that the parents responded to the patient in certain ways–such as by condemnation, reproach, contempt, or what not–which promoted illness in the child, the therapist will refuse to tie his own hands with any self-imposed injunction to make his own behaviour always an antidote for such early trauma, and never to engage in such responses himself. He knows that there will be times when these are the only realistic responses to make to a given piece of behaviour on the patient's part, and he rests assured that if the patient were never able to find *anything* of the latter's mother or father in the therapist, the transference-reliving, and eventual resolution, of the schizophrenic illness would be impossible. We could postulate with some confidence that a person whose intrafamilial relationships had been so warped as to lead to schizophrenia would quite simply be at a loss to know how to relate, would have insufficient tools from past experience for relating, to a hypothetically ideally loving and mature therapist.

The therapist learns to take fewer and fewer things for granted in this work, to question more and more of his long-held

assumptions and discard many of them. He learns that one does not set a ceiling upon any human being's potential growth. He finds recurrent delight in the creative spontaneity with which the schizophrenic patient pierces the sober and constricting wrappings of our culture's conventions, and he discovers that humour is present in this work in rich abundance, leavening the genuine tragedy and helping to make it supportable. While developing a deep confidence in his intuitive ability, when working with the severely fragmented or dedifferentiated patient he will not jump too quickly to attempt communicational 'closure' (in the Gestalt sense), but will leave it in the patient's hands to do, no matter how slowly and painfully, the parts of the communicational work which only he can do. Meanwhile, he will not need to shield himself, through the maintenance of an urgently and actively 'helpful' or 'rescuing' attitude, from feeling at a deep level the impact of the fragmented and dedifferentiated world, with its attendant feelings, in which the patient exists. The unfolding of such feeling experiences, which will be elaborated in my portrayal of the next phase of the therapy, the 'urgently helpful' therapist attitude is unconsciously designed to avert, comparable to the defensive function, in the patient, of the latter's schizophrenic delusions.

I hope I have made it sufficiently clear that, in describing a basically neutral feeling-orientation towards the patient, I am not thereby recommending that the therapist should assume, and hold to, any rigid professional role of 'the psychiatrist'. My experience of this coincides with that indicated by a number of workers in this field. Robert A. Cohen (1947) reports, concerning his therapy of a paranoid schizophrenic woman, 'the patient's unfavourable reception of any remark which smacked of the usual psychiatric jargon',' and learned to avoid becoming so interested in the *content* of her delusions as to lose track of their *feeling*-implications for the patient. Lidz and Lidz (1952) point out that: 'More paranoid patients, in particular, can participate in treatment but cannot be treated in the sense of having another person control or manage them.' Bullard (1960) offers to the paranoid individual 'not interpretations but, rather, hypotheses for the patient to consider as possibly shedding some light on the problems he is exploring'. The basic orientation I recommend is well described in Loewald's (1960*a*) remarks about psychoanalytic work,

> . . . Through all the transference distortions the patient reveals rudiments at least of that core (of himself and 'objects') which has been distorted. It is this core, rudimentary and vague as it may be, to which the analyst has reference . . . and not some abstract concept of reality or normality, if he is to reach the patient. If the analyst keeps his central focus on this emerging core he avoids moulding the patient in the analyst's own image or imposing on the patient his own concept of what the patient should become. It requires an objectivity and neutrality the essence of which is love and respect for the individual and for individual development . . .

The Phase of Ambivalent Symbiosis

To the extent that the therapist's basic orientation towards the patient is a neutrally investigative one, free from a compulsive need to help and to love the patient, but open, rather, to the sensing of hateful as well as loving feeling-tones in the therapeutic relationship, he comes progressively to detect the intense ambivalence which has been locked within the patient's psychotic symptomatology. He detects this, before the patient himself has become able to experience and verbally express such ambivalence, through the awareness of sudden fluctuations of his own feelings in reaction to the patient's verbal and non-verbal communications. He finds his feelings towards the patient switching unexpectedly from, for example, tenderness to contempt, or from fury to grief, or what not. He finds himself experiencing, on occasion, feeling states which are quite ineffable and foreign to his memory and which, despite whatever roots in his own preverbal childhood, can usefully be regarded as samples of the feeling states at work in the patient himself, though, more probably than not, as yet outside the latter's awareness.

The prolonged silences, or obscurity of verbal communication, or both, which characterize work with the chronic schizophrenic patient have served to foster a progressive weakening of ego-boundaries between patient and therapist. That is, in this situation of clouded communication, projection and introjection on the part of each participant is facilitated to an extent which is seldom if ever seen in an analyst's work with a neurotic patient, for in the latter instance the frequent and clear verbalizations, from each participant, tend to keep *relatively* clearly in view the ego-boundaries between the two participants. Thus there

develops a generous reality basis for the symbiotic transference which the schizophrenic patient tends powerfully, in any case, to form with his therapist. The therapist's own ego-boundaries are weakened not only in reaction to the prolonged silences and in reciprocity to the patient's transference, as indicated in the above-mentioned comment by Mabel Blake Cohen, but also for the reason that regression towards symbiotic relatedness tends to occur in the therapist himself as an unconscious defence against the intense and deeply ambivalent feelings–of helplessness, fury, loathing, tenderness, grief, and so on–evoked by his relationship with the schizophrenic patient, long before that relationship has become strong enough and well-defined enough to permit his recognition of these feelings, and any full-scale expression of them, towards the patient.

As I have described in chapters 8, 10, and 11, the therapist at times will find himself in the extremely uncomfortable state of experiencing two quite different, and subjectively unrelated, feeling attitudes towards the patient simultaneously. Particularly in instances in which one or other parent was psychotic, the patient tends to form such a subjectively ego-splitting kind of transference towards the parent-surrogate therapist. The relatedness between patient and therapist comes, sometimes for several months, to bear many of the earmarks of a mutual effort to drive each other crazy (ch. 8). I have described in chapter 6 some of the manifestations of the patient's vulnerability, during this phase, to the disturbing impact of the therapist's unconscious processes.

More and more the therapist comes to feel enmeshed, as it were, in the patient's own ego-fragmentation and dedifferentiation. The therapy has a sticky feel about it; the therapist feels restrained from any decisive actions, incisive comments, or even clear-cut and unambivalent feelings towards the patient. His resentment, rage, and hatred towards the latter are tormentingly guilt-provoking in nature; and his tender and loving feelings are hardly less burdensome and guilt-provoking. He feels that he does not truly love the patient, but has only an ugly lust which will not stand the light of day; and when he does feel that his love is more of a parent-to-child order, his love feels guiltily possessive. He is painfully aware of being like a jealous Pygmalion concerning this Galatea with whom is he at once blessed

and afflicted: he looks to his colleagues for succour, but deeply resents any participation from a third person–psychiatric administrator, therapeutic supervisor, nurse, or whomever–as an intrusion into his own private domain. One other simple earmark of this phase of ambivalent symbiosis is the circumstance that the relationship with this patient has assumed an absorbing, unparalleled *importance* in the therapist's life, an importance which not only jars with such relationships with other staff-members as impinge upon the situation, but which he experiences also as a competitive threat to his most personal and cherished non-professional relationships.

At its fullest intensity, this phase is experienced by him as a threat to his whole psychological existence. He becomes deeply troubled lest this relationship is finally bringing to light a basically and ineradicably malignant orientation towards his fellow human beings. He feels equivalent to the illness which is afflicting the patient; he is unable to distinguish between that illness and himself. This is not sheer imagination on his part, for the patient is meanwhile persistently expressing, in manifold ways, a conviction that the therapist constitutes, indeed, the affliction which threatens to destroy him and with which he, the patient, is locked in a life-and-death struggle. In my theoretical view, the therapist is now experiencing the fullest intensity of the patient's transference to him as the Bad Mother.

The patient's own ego-boundaries may be so unclear that it may be impossible to know whether, when he speaks, he is uttering thoughts which are subjectively his 'own', or rather giving voice to what he assumes the therapist to be thinking but not expressing. The therapist will often find it similarly impossible to know whether a predominant feeling-tone of anger, or grief, or what not is welling primarily from the patient or from within himself.

Murderous feelings arising within the therapist tend particularly, in contrast to more readily acceptable feelings, to become projected upon the patient, whose own oftentimes prominent assaultive tendencies offer a ready reality-basis for such projections. The therapist in these circumstances is prone, for various reasons some of which are quite obvious, to the development of intense murderous feelings. These result from the intense frustration of his therapeutic endeavours, the threat to his

individuality arising from the symbiotic relatedness with the patient, and his residual of infantile omnipotence brought to bay during the mutual regression which this symbiosis involves, such that the therapeutic relatedness often takes the form of a raging struggle between two gods. There thus supervenes all the murderousness of the thwarted infant not only in the patient but in himself also.

Uncomfortable though it is for the therapist to feel afraid of the murderous patient, it is still harder for him to realize the full extent of his own murderousness towards the patient, and to see that the latter is unaware of feeling murderous and is experiencing, instead, intense fear of the therapist who is viewed as murderously insane. It is more acceptable to the therapist's superego to feel intimidated than intimidating, and the realization that the patient is deathly afraid of one tends, at least initially, to weaken one's own feeling of control over one's rage.

I have reported in chapter 6 a dream which I had during the course of my work with a hebephrenic man whom I had been viewing, for some months, as being a dangerous, uncontrollable person. In the dream, during a desperate struggle between us he got his hands on a knife-like letter-opener. But then *he* took *me* into custody, and at the end of the dream he was functioning as a kind of sheriff's deputy, marching me out to turn me over to the authorities. This dream was one of the developments which helped me to become aware of massive, previously repressed rage in myself which I had been projecting on the patient. A colleague reported to me in a supervisory hour, two weeks ago, the uneasy feeling that he and the patient were presently in a state of ostensible calm which was really the calm, he sensed, of the eye of a hurricane; he felt that there was some as yet undefined fury in the patient which was looming somewhere. But in last week's supervisory session he reported various intimations of a previously unsuspected quantity of rage in himself, such that he said, 'I'm not sure now whether the hurricane is in her or in me.'

More often than not the therapist is, unlike this colleague, unaware that a state of symbiosis is developing, or has long been established, between the patient and himself. This state of affairs is easier to detect in one's colleagues than in oneself. When one

becomes alert to the significance of this phase of the therapy with the schizophrenic person, one is struck by how frequently one hears therapists make, in supervisory sessions or in staff presentations, such comments as 'There's been a lot of anger this past week', without specifying in *whom*; or, likewise, 'There's a manicky mood around–there's a lot of giggling'; or, 'There is a very strong dependency there', without specifying *where*. The therapist may make repeated slips of the tongue concerning the sexual identity of the patient–a response not only to the deep-seated sexual confusion in the patient which has now come to light, but a function also of the therapist's lack of differentiation between his own sex and that of the patient. He may say, 'I started seeing her in [a cold, wet sheet] pack', in such an ambiguous tone as to make one wonder momentarily whether he means that she was in pack, or he was in pack, or both were in packs. On rare occasions one may hear: 'The first period when he was my therapist was –I mean, the first period when I was his therapist was. . . .' One becomes alert to such clues in one's own presentations also.

The dissolution of ego-boundaries between patient and therapist is only a major aspect of a more general dedifferentiation and disintegration of ego-functions which occurs in both participants (although to a much lesser, and therefore more subtle, degree in the therapist, of course, than in the patient) as the symbiotic relatedness develops. Thus the therapist, losing temporarily his ability fully to differentiate between fantasy and reality, may react to various of his sexual fantasies about the patient with as much guilt as though they represented consummation in behavioural reality, and may feel jealous of the hallucinatory figures with which the patient is immersed in a seemingly lively and intimate interaction, as though these hallucinatory figures were to be compared on a par with himself (Searles, 1961*c*). On occasion, too, during this phase, childhood scenes have welled up in my memory with an almost overpoweringly tangible reality. One feels from time to time, too, the impact of some previously unglimpsed fragment of the patient's past, conveyed to one now by him in ways that are largely nonverbal and hard to objectify.

Before this phase of ambivalent symbiosis can give place to the succeeding one in the therapeutic sequence, the relationship

between patient and therapist must gradually grow, through the resolution of innumerable and increasingly severe tests of the kind mentioned above, strong enough for the therapist to be able to endure the fullest intensity of the patient's hostility, focused directly upon him. In contrast to the warnings given by Sullivan (1956), Hill (1955), and many other writers, to the effect that such a development means that the therapy has foundered irretrievably, I have come to see this, both in my own work and in that of my colleagues, as an utterly essential therapeutic development. The patient can never become deeply a whole person unless he has this chance, in Hoedemaker's (1955) way of describing it, to identify with the therapist who survives the fullest intensity of this kind of attack to which the patient was exposed in childhood and from which he, the patient, had to flee into psychosis. And complementarily, I have found that it is an equally essential part of this phase that the therapist finds himself gradually coming, step by step, to express openly—even though not as often as he feels it within—the very fullest intensity of his own hatred, condemnation, and contempt towards the patient, expressing these in ways which are unconsciously patterned after those ways by which the parents expressed their destructively negative feelings towards the patient as a child; the therapist's responses are so moulded, in powerful degree, by the patient's transference, and it is thus that the patient is at last able successfully to cope, symbolically, with the parents' destructiveness, recapitulated in the therapist's side of the transference relatedness. The deep reassurance which therapist as well as patient derive from finding repeatedly that each can survive the other's, and his own, baring of hatred at its fullest means that the foundation for the next therapeutic phase, that of full—or, genetically speaking, preambivalent—symbiosis has now become established.

The Phase of Full, or Preambivalent, Symbiosis

This phase, which is ushered in gradually and—as in the instances of the other phases I am describing—with unceasing fluctations towards both earlier and later phases, most often makes its presence known in terms of the therapist's finding, to his surprise, that his largely silent hours with the patient are no longer predominantly a source of conflict and anguish to him,

but rather mainly one of pleasureful contentment, contentment which his superego at first reacts against as being reprehensible in view of the still formidable degree of illness in the patient after the passage of these many months of treatment. Or the therapist may discover, in the course of work with a largely verbal patient, that their verbal encounters have somewhere along the way lost their disturbing, anxiety-provoking, and hurtful quality, and are now predominantly, though largely deniedly, cherished by them both.

The therapist now comes more and more unconflictedly to accept both the feelings of a Good Mother who has a godlike importance to the little infant in the patient, as well as his own equally infantile-dependent feelings towards the patient as a similar Good Mother; the therapeutic relatedness, having progressed to the preambivalent mother–infant symbiosis, oscillates between the therapist's being now in the one position, now in the other, towards the patient.

I cannot overemphasize the extent to which it is the little child in each participant upon whom mutual trust must eventually be placed, for therapy to succeed; in the Biblical phrase, '. . . and a little child shall lead them' (Isa. xi. 6). Psychotherapy with the schizophrenic patient tends naturally to involve the therapist's feelings at the level of his own early childhood experiences. He powerfully responds to the patient as being an omnipotent mother, both because the latter's history of prolonged symbiotic relatedness with the mother has fostered strongly maternal qualities in the patient, and also because the present deeply undifferentiated state of the patient's ego gives the therapist the impression of unlimited potentialities for his own gratification.

One's love for the patient is now experienced as boundless and unthreatening, no longer a threat to, for example, one's relationship with one's wife and children, but rather a confirmation of one's ability to love anyone whatever. The sexual components of the love are no longer experienced as predominant, but submerged in a kind of boundless, fundamentally maternal, *caring for* the patient. This love, experienced towards the patient of one's own sex, is no longer experienced, as it was previously, as being any threat to one's sexual identity. Such hateful feelings as do from time to time arise become progressively guilt-free and

actively enjoyable, on the whole much subordinate in power and frequency to loving feelings, and increasingly rapidly revealed as defensive against the intensely tender love which underlies them. One comes to see that, at this level of dedifferentiation, 'love' and 'hate' are one, and that any intense and overt relatedness is, in effect, love. One of my patients, during such a phase, expressed her realization that 'There's a very thin line between love and hate'.

The patient's formerly archaically harsh superego is now seen progressively as no longer a giant foreign body in the patient–therapist relatedness, but rather as the vehicle for the patient's expression of his most deeply denied, but at the same time most intense and intimate, love for the therapist-mother. Comparably, the therapist finds that his own vestiges of infantile omnipotence, fanned to flame by the 'struggle-between-two-gods' nature of the ambivalent phase of symbiosis, give way to a realization, and deep acceptance, of his inability to 'cure' the patient through any exercise of rageful, godlike authority–his inability, that is, to bend the patient to his will by 'curing' him. There emerges in him then a feeling-orientation which, achieving what I have experienced as a 'gentle victory' over the domineering god-infant in oneself, is felt, for all its quiet gentleness, to be awesome in its power: a loving acceptance of the immediate relatedness with the patient, founded upon the knowledge that one's now full and unswerving dedication to his recovery, mingled with the patient's own increasingly liberated striving towards health, together make up a current which is carrying the therapeutic process forward. Out of this whole-hearted commitment of feeling by both patient and therapist, we understand the accuracy of the comment made by Bak (1958), that to the degree that the adult person is truly mature, there is in him no realm of the superego, demarcated as such within the over-all functioning of the personality; and of Anna Freud's (1946) observation that '. . . our picture of the superego always tends to become hazy when harmonious relations exist between it and the ego. We then say that the two coincide. . . .'

The therapist experiences not only the above-mentioned sense of whole-hearted commitment to the therapeutic relationship, at a depth which, he now realizes, despite all his previous expenditures of effort and feeling, he never felt before; he responds

to the patient, during the therapeutic session, as being of boundless personal importance to him, and becomes progressively unafraid to acknowledge this on occasions when the patient needs such acknowledgement. It is not too much to say that the therapist feels the patient as necessary, even, to complete himself; temporarily and acknowledgedly, that is, he feels towards the patient that which the 'schizophrenogenic mother' was not strong enough either to acknowledge or to relinquish: the need for the patient to complete her own personality. For years we have been accustomed to damn this phenomenon totally as wholly destructive, and productive of schizophrenia; we need to realize that the core of any human being's self esteem is traceable to the healthy infant's experience that he is indeed needed to complete the psychological wholeness of the mothering person; it is there, I have come to believe, that the core of the *raison d'être*, for each of us, is to be found.

By the same token, the therapist should not be ashamed to receive from the patient such help in personal integration as he is able to provide; in this regard I fully concur with Whitaker and Malone (1953). The healthy child's self-esteem is strengthened by the experience that, just as his mother needed him to complete herself in his infancy, she now finds him deeply helpful in fostering her personal integration, her maturing. We should be able to have the courage to see and acknowledge these aspects of the symbiotic core of therapeutic interaction, when we see that, as long ago as 1923, Groddeck (1923) had the courage to describe how, in his treatment of one of his patients:

> . . . Her childlike attitude towards me–indeed, as I understood later, it was that of a child of three–compelled me to assume the mother's role. Certain slumbering mother-virtues were awakened in me by the patient, and these directed my procedure. . . . And now I was confronted by the strange fact that I was not treating the patient, but that the patient was treating me; or, to translate it into my own language, the It of this fellow-being tried so to transform my It, did in fact so transform it, that it came to be useful for its purpose. . . . Even to get this amount of insight was difficult, for you will understand that it absolutely reversed my position in regard to a patient. It was no longer important to give him instructions, to prescribe for him what I considered right, but to change in such a way that he could use me.