The therapist, at moments when he is in the position of the mother in the mother-infant symbiosis, may have vivid fantasies of giving suck to the patient as a happily nursing infant; Warkentin and Taylor (Whitaker, 1958, pp. 79–84) have described the physical accompaniments of such fantasies, and I, too, have experienced these in my work with a number of patients. It is equally important that the therapist become able to accept his nursing-infant fantasies towards the patient, whether female or male, for otherwise the patient cannot learn deeply to accept his own desires to nurture–the primeval basis for all givingness. I find it impressive, in this connexion, that Sèchehaye (1951), Eissler (1951), Schwing (1954), Hayward and Taylor (1956), Whitaker and Malone (1953) and many other therapists are in agreement concerning 'the absolute necessity for a happy infantile experience with a good mother before the patient can begin to grow toward adult reality' (Hayward and Taylor, 1956, p. 211), and it is of additional interest that the recovered schizophrenic patient reported by Hayward and Taylor, who gave a detailed account of her therapy as she saw it in retrospect, 'stressed that the happy nursing experience was the most important single part of her therapy'. I am trying here to describe something of how this particular phase of the therapy, this 'happy infantile experience with a good mother' phase, actually manifests itself, particularly in terms of the therapist's experiences during it.

A mutual spirit of childlike playfulness is another prominent characteristic of this phase. Because the ambivalent stage of the symbiotic transference relatedness has been successfully traversed and the stratum of preambivalent lovingness attained, the lack of structure, the lack of rigidly defined boundaries between patient and therapist, or between such intra-psychic realms as those of remembered 'reality' and those of creative fantasy, or those of concrete imagery and those of metaphorical or allegorical or otherwise highly figurative imagery, is experienced no longer as a threatening kind of dedifferentiation, but rather as giving both participants the unfettered opportunity to trade places playfully with one another (and even, in one instance in my experience, imaginatively to trade various body-parts with one another), and to gambol playfully about all these various realms of psychological experience in a mix-up which is often-

times thoroughly merry to both of them. One finds something which one had never thought possible: confusion itself, usually regarded in psychiatry as so tragically destructive to the patient and threatening to his therapist, can be actively pleasurable in an atmosphere where such a degree of mutual trust has been reached that, where hate for all practical purposes does not exist, confusion is no longer tantamount to vulnerability, and ego-structure need not be thrown up as a poorly erected bulwark against external threat, but can form at its own pace as, primarily, a growing organization for the expression of increasingly complex inner potentialities and therefore needs.

It is appropriate at this juncture to note the impact upon the total hospital environment of the foregoing phase in the psychotherapeutic relationship, namely the phase of ambivalent symbiosis, and of this phase of full or preambivalent symbiosis. In the former phase the patient-therapist relationship tends to foster incessant and severe splits among the group of patients and personnel on the ward, pervading, at times, the social structure of the whole hospital. In the same way, the deep ambivalence in the patient, as well as the not inconsiderable ambivalence roused responsively in the therapist in the course of the therapy, tend to make their relatedness the ready instrument for the expression of already existing, latent disagreements rife in the social environment surrounding them; thus, of the ambivalence which permeates this larger social environment, their therapeutic relationship is at once cause and victim. Such ambivalently symbiotic phenomena in the larger social structure of the hospital have been well described by Stanton and Schwartz (1954), Main (1957), Perry and Shea (1957) and others; I have reported my own experience with, and interpretations of, such phenomena in chapter 11.

Many a therapeutic relationship miscarries, and therapist and patient, unable to face and resolve the intense, mutual hatred which is evoked by the symbiotic phase of the psychotherapy, repress this hatred, project it on to various figures in the surrounding social matrix of the hospital, and become locked in a relatedness in which they both share the fantasy of being lovingly at one. But this is not the truly preambivalent phase of the transference symbiosis which they are experiencing; rather it is, as those responsible for the long-run management of the hospital

are painfully and irritatedly aware, predominantly a *folie-à-deux* between patient and therapist, in which symbiosis is functioning mainly as a defence against the recognition of mutual hatred. This development is so common that I have come reluctantly to conclude that there is no sure criterion by which we can know, for long periods of time, whether we are involved in a genuinely preambivalent symbiosis with the patient, or rather in the predominantly paranoid symbiosis which is a defence against hatred; there is no kind of litmus paper which will definitely tell us, and we must remain open-minded to the ever-present possibility that, for example, a basically constructive, subjectively preambivalent symbiosis will be misused unconsciously from time to time, by both participants, to keep increments of particularly intense hostility out of awareness.

Even in those treatment relationships where a healthy, preambivalent symbiosis has full sway, it is not always easy for the social environment to take. The therapeutic relationship even here needs a kind of delicate handling, much as a pregnant woman needs special care from her environment even when the pregnancy is progressing well. For example, neither therapist nor patient is yet ready for any third person to come upon the scene as a consistently valued, and openly acknowledged, contributor to their mutual therapeutic work. Further, the subjectively irresponsible playfulness and contentment, so genuinely healing in itself and so central an ingredient of the preambivalent symbiosis, nonetheless strains the faith and patience of others on the hospital staff who have little or no opportunity to participate in the favourable developments I have been describing, and who are aware mainly of such conspicuous factors as the patient's already long hospitalization, his persisting manifestation of various chronic symptoms in his daily life on the ward, and perhaps, the intimations from the family that this hospitalization cannot be underwritten indefinitely.

'They were going around on a merry-go-round–no, not on a merry-go-round, because that implies movement', snorted a supervisor at a recent staff conference, concerning the therapeutic relationship between a hebephrenic woman and her therapist who were, from my viewpoint, in the midst of the phase of preambivalent symbiosis at a time when, for extraneous reasons, the therapist had had to leave Chestnut Lodge to

return to his distant home country. 'Going around on a merry-go-round' is a beautiful way of describing the kind of therapeutic interaction in which it is so important for the patient and therapist to become able freely to participate, but which is so difficult for the hospital organization to permit. I myself, who 'know' these things as well as I know anything about the therapy of schizophrenia, feel, when in the role of supervisor hearing from a therapist concerning his work during such a phase, unenjoyably aware of being an 'outsider' to the intimate two-person relatedness I am hearing about at second hand, and must work against my tendency to express envious resentment to the therapist through admonitions and reproaches that he should buckle down to the business of psychotherapy with the patient–the worst possible supervisory response at this phase of the therapy. By contrast, the sheepish therapist obtains invaluable help from his supervisor's realization that what is going on in therapy is the very essence of what is good for the patient, confirming the therapist's own courage to go on doing this in the face of the reproaches of his own all too conscientious superego.

The Phase of Resolution of the Symbiosis

The complex individualistic needs of the two participants, and thus their respective strivings for individuality, will not tolerate indefinitely the perpetuation of the therapeutic symbiosis. The basic function of this symbiosis is, after all–despite the intense regressive gratification which it holds in itself–a maturational one: it provides the patient, and to a not insignificant degree the therapist also, with a basis for renewed, and healthier, development of individuality. Thus, after a period extending, as best I have been able to determine, from a few months to one or two years, the dynamic equilibrium of the therapeutic relatedness shifts increasingly towards resolution of the symbiotic phase. The initiative for this shift may be manifested first by either patient or therapist, and it is my impression that the resolution process–that is to say, the process of both participants' coming to be subjectively, and to function as, individual persons, rather than partners in symbiosis–proceeds by turns, with now one, and now the other, showing the greater push towards emancipation. I shall describe first the therapist's experiences when the initiative

is in his hands, and then his experiences in reaction to the patient's showing such initiative.

One of the therapist's typical feelings, in the former instance, is a quiet, subjectively unaccountable, but deeply memorable sense of apartness from the patient, a feeling-realization that the patient is outside oneself–a realization that he is a person 'over there', a person afflicted with a schizophrenic illness which is, likewise, 'over there' in the patient. One facet of the therapist's realization is, then, that he–the therapist–is not the patient's illness. This shift in feeling orientation is at times experienced, also, as a sensation of now being, at long last, 'out of love with' the patient–a feeling always, for me, tinged with some guilt in those instances in which he is still showing much need for persisting symbiosis with me beyond the time when I have now 'outgrown' it.

On other occasions, the therapist experiences a resolution of the symbiosis, or at least a step in this resolution process, not in this quiet and subjectively inscrutable way, but rather with a sudden sense of *outrage*. The very word '*out*rage' is significant, and the feeling it designates is qualitatively different from annoyance, anger, or even rage. He feels outrage at this or that chronic regressive symptom in the patient, or outrage at the latter's whole regressive symptomatology, and always outrage at the unreasonableness of the demands which the patient has been making upon him these many months or years. He sees the enormity of these demands which the patient has been placing, through his illness, upon him and other persons, and sees clearly the folly of acquiescing further in these regressive demands. He is suddenly and vigorously determined to give no more of his long-time dedication, now seen as misplaced dedication, to the gratification of these demands, which he formerly saw as infant needs which it would be unthinkable to brush aside.

The therapist sees now, by the same token, the full interpersonal offensiveness of the patient's defence mechanisms, whereas he possessed heretofore a high degree of tolerance for such offensiveness in his patient and maintained a devoted effort to see, and empathize with, the anxiety, the hurt, the loneliness, and so on, against which the patient has been unconsciously protecting himself through the use of these defence

mechanisms. In my work with, for example, one paranoid schizophrenic man who chronically manifested intense scorn and sarcasm in his dealings with other persons including myself, for nearly two years I had experienced increasing forbearance towards and sympathy with him as I saw more and more clearly the feelings of hurt, disappointment, and so on which the scorn and sarcasm was serving to maintain under repression. But then, with the advent of the resolution-of-symbiosis phase, it forcibly dawned upon me how genuinely obnoxious, to me as well as to others, he was being with his scorn and sarcasm, the defensive function of these notwithstanding.

In other words, one now holds the patient highly responsible for his symptoms. One now leaves in his hands the choice as to whether he wants to spend the remainder of his life in a mental hospital, or whether he wants, instead, to become well. In every instance that I can recall from my own experience, I have found occasion to express this newly won attitude to the patient himself, emphasizing that it is all the same to me. These are no mere words, but the expression of a deep and genuine feeling orientation. One cares not, now, how callous this may sound, nor even whether the patient will respond to it with suicide or incurable psychotic disintegration; and one feels and says this while casting one's own professional status, too, into the gamble, not to mention the potential feelings of lasting remorse to which one might be subject in case one's communication had such an irremediably destructive effect upon the patient. Thus, in effect, one braves the threat of destruction both to the patient and to oneself, in taking it into one's hands to declare one's individuality, come what may.

It may well be that individuation–the resolution of symbiosis–innately contains, even in the healthy maturation of the young child, this element of going ahead in the face of such a life-and-death threat. Incidentally, if this is true, we have here the primordial determinant of democracy's tenet that it is better to brave death than to live as anything other than a politically free individual.

Part of this new attitude on the therapist's part is a readiness to let the patient 'stew in his own juice', in contrast to his having often found himself, previously, vicariously expressing the patient's feelings in the symbiosis which then obtained. Likewise,

he feels a new freedom to express his own individual thoughts and feelings to the patient as an individual–or, at any rate, as one whose nascent individuality is increasingly in evidence–without being hampered by concerns as to whether he is being inconsistent towards him, or is treating the latter unfairly in comparison with his other patients–a not unimportant aspect of the work when one has two or three patients on the same hospital ward.

The therapist feels a clear realization, with all this, of the fact that he himself is no longer indispensable to the patient; he realizes, that is, that he himself is not the only conceivable therapist who can help the patient complete the journey to health. He can look about him and see various colleagues, who he can readily imagine, would fill this capacity as well as, or possibly better than, he can. He feels now a lively appreciation, a genuine welcoming, of the invaluable contributions to the patient's recovery which have been, are being, and will continue to be made by nursing staff, relatives, various other patients on the ward, and so on. This is in marked contrast to the therapist's feeling earlier in the work, a grandiose feeling but, I think, a feeling quite essential to the development and maintenance of the therapeutic symbiosis, of being a God the Creator in the therapeutic situation, of being the only conceivable Pygmalion for this Galatea; that feeling was, after all, of a piece with the mother's sensing of her own god-like indispensability to her so needful infant. The therapist's subsequent realization, now, that these others are helping in major ways to meet the patient's needs, comes predominantly as a deeply reassuring one; but it has, obviously, affective ingredients of deflation and loss.

We see the loss-aspect of the therapist's experience more clearly at those junctures when the patient rather than the therapist is manifestly showing a determination to grow free of the symbiosis. One of my most frequent experiences as a supervisor is that of helping a therapist to explore his feelings of dissatisfaction and despair about a current therapeutic relatedness in which, he is consciously convinced, the schizophrenic patient is showing discouraging stasis, but is actually evidencing, as shown by various subtle clues, all too many indications of a growing, though still somewhat submerged, determination to slough off the symbiosis in which the therapist has a far deeper feeling-investment than he cares to acknowledge to himself.

The therapist paradoxically finds himself despairing, for example, just at the time when the patient has actually been opening up unprecedentedly deep areas for investigation–areas of fondness and dependency towards the therapist, areas of confusion or other disturbed subjective experience, and so on. One unconsciously employs, as therapist, the same defence mechanisms against recognizing the beginning resolution of the symbiotic phase as one employed earlier against the recognition that this phase of symbiosis was becoming more and more deeply established–namely the defence mechanisms of denial and reaction-formation: the denial of how well the work is actually proceeding, of how much the patient means to oneself, of how deeply cherished are the gratifications which one is obtaining or has been obtaining, of how deep is the sense of loss which further change will bring; and reaction-formation feelings of impatience and dissatisfaction, as part of one's struggle to maintain under repression feelings of contentment, satisfaction, and accomplishment.

I think it correct to say that the therapist, no matter how mature or experienced, inevitably reacts somewhat against any move on the patient's part into a new area of feeling, a new area of psychotherapeutic investigation. This is partly for the reason, as I have said in chapter 15, that the patient's sense of identity is so deeply invested in the old way of experiencing things, the old and familiar way of relating to the therapist, that he would experience a major threat to his sense of identity if the therapist were somehow able to welcome with unambivalently open arms this move into a new area of experiencing and interpersonal relating. But it is partly for the reason, too, that the therapist has a more or less deeply imbedded emotional investment in the familiar, more predominantly symbiotic mode of relatedness with the patient, and hence reacts against the threat of personal loss with which the patient's new growth as an individual confronts him.

I have had the experience of finding that a hebephrenic woman, with whom I had been involved for a number of years in an increasingly unambivalent and pleasurable symbiotic relatedness, had come to radiate–with disconcerting suddenness, so it felt to me–a self-containment which, by all logical standards, was a most welcome therapeutic development. Instead of

making unceasing efforts for me to be everybody to her and to satisfy her every need almost before it arose, she now spent the hours with me in saying little, but mainly looking at me calmly, appraisingly, and objectively. She was not being actively rejecting to me, in either word or facial expression, as she had been on innumerable occasions much earlier in our work, particularly during the phase of ambivalent symbiosis. But I felt a distinctly unpleasurable sense of being apart from her; I could not help feeling rejected in the face of a development which I knew represented, for the first time, the establishment of a genuine sense of self on her part.

For the patient to become firmly established as, subjectively, an individual person, he must come to accept that, although he can contribute to the healing of other persons'–including his therapist's–psychological difficulties, he cannot cure them in any total sense, and therefore does not have to hold himself responsible for curing them. He can proceed, therefore, with the getting-well process, the process of becoming an increasingly healthy person, without *guilt* for being, and increasingly becoming, a separate individual. This is one of the dividends which the relinquishment of infantile omnipotence yields to the patient–a relinquishment which is part of the relinquishment of the mother–infant symbiosis in the transference.

From the therapist's viewpoint, he must come to accept that, although the patient has been of deeply personal help to him, the patient cannot totally 'cure' him–that he will have to struggle towards increasing maturity, increasing personal integration and differentiation, in future courses of work with the patients who will succeed this one, and he may glimpse, now, the basic truth–if so it be, and I surmise that it is–that the ideal of 'complete maturity' is only one of the disguises worn by the persistent striving, within him, towards infantile omnipotence. Loewald (1960*b*) speaks of the valuable role, in superego formation in healthy development, of manageable increments of disillusionment. The successful resolution of the symbiotic phase of therapy with the schizophrenic patient requires, likewise, that each person be able to integrate his disillusionment about his own and his partner's powers, shrunken now from omnipotent to lifesize proportions.

It has seemed to me, both in my own work and in the material

reported by colleagues in supervision and elsewhere, that the patient has first to demonstrate to himself that the therapist is not omnipotent, but rather–at this moment, at least–totally helpless, before he can feel it permissible to go ahead and function, capably, as an individual. This seems in part a function of the vulnerability to guilt-about-being-a-separate-person to which the schizophrenic person–and, I believe, to a lesser extent the neurotic person also–is so prone. It is as though he has to exhaust every possibility of getting help from the therapist–about whatever issue is at hand–before he can himself allow his own constructive potentialities to come to the fore, and meet the issue at hand in his own functioning individuality. Thus is it no coincidence that the emergence of the patient's individuality tends to occur in a setting of the therapist's feeling more than usually helpless in the situation. We can think of it from the viewpoint, also, that no one, whether adult patient or healthy child, would give up a therapist (or, respectively, a parent) who is, as far as can be determined, omnipotent; human beings are, if nothing else, practical, and this would be simply impractical: it would make no sense to individuate oneself from such an omnipotent being.

It is worth noting, further, that if the therapeutic relationship is to traverse successfully the phase of resolution of the symbiosis, the therapist must be able to brave not only the threats of suicide or psychotic disintegration on the patient's part, and of the professional and personal destruction to himself which might be a correlate of such outcomes; he must also brave the threat, which seems at times to be of a comparable order of magnitude, that the patient will, after these arduous years have passed and the home stretch is in sight, change therapists. It is as though the patient, by presenting the therapist with this threat of separation and finding that the latter can face it squarely without resort to panicky efforts to re-establish their erstwhile mother-infant symbiosis, gains the reassurance that the therapist will allow him to become a person in his own right, and to regard the recovery from psychosis as predominantly the patient's own achievement, rather than as a feather in the therapist's cap.

An important step in individuation for one of my patients, with whom I had been working for seven years, occurred when I allowed her to use my telephone, during one of her sessions with

me, to call the Director of Psychotherapy for an appointment to discuss her desire for a change of therapists. In retrospect I have seen this as a crucial experience for her, that I freely allowed her to do this although her changing therapists would have meant a great personal loss to me, and although I felt it quite possible that she might succeed in that endeavour.

Incidentally, my readiness to face this development was, I think, one factor which enabled her to explore soon afterwards, in her sessions, her desires, repressed since childhood, for a different set of parents. This transference-development tends, I think, to occur comparatively late in treatment, when the therapist is likely to think the patient painfully ungrateful for wanting, in the transference, a different therapist. I have mentioned in chapter 12 how apt the patient is to press for a change of therapists just at a time when he is threatened with beginning to recognize how greatly he himself has changed, a recognition which tends to disrupt his still tenuous sense of personal identity; in the context of this paper, he tends to flee from the recognition of his having undergone the great change of individuation–tends, in Erich Fromm's (1941) phraseology, to flee from the freedom of individuality, by seeking a symbiotic relationship with a new therapist.

The resolution-of-symbiosis phase is always complicated, often to a marked degree, by the resistances which various persons in the patient's life between therapeutic sessions, including the family members, some of the nursing staff and, it may be, some of his fellow patients, pose to his becoming a separate person and depriving them, therefore, of such symbiotic gratifications as the therapist himself has come to know, and reluctantly to relinquish, in the transference relationship. It is by now a truism that the family members, no matter how genuinely fond of the patient and devoted to him they are at a conscious level, are particularly likely to withdraw him from the hospital just at the point when his individuation is promising to become established; and the therapist is not the only member of the hospital staff who inevitably acquires, over the years, a deep emotional investment in the patient's remaining ill and symbiotically oriented towards the more significant among his fellow human beings. But that aspect of the matter has been discussed already in the literature to a considerable extent, and any detailed examination of it

would carry us beyond the intended focus of the therapeutic relationship itself with which I am here primarily concerned.

The Late Phase

This phase extends from the resolution of the therapeutic symbiosis up to the completion of the therapy. It is a long phase, for only with the resolution of the symbiotic mode of relatedness is the patient capable of genuine object-relatedness and able, therefore, to cope with the matters with which psycho-analysis of the neurotic individual ordinarily deals. Only now, that is, is he ready for psycho-analysis; thus this phase requires a number of years of continued work.

Now that his symbiotic mode of relatedness has been resolved, the patient becomes involved in a better differentiated, more selective, process of de-repression of identifications from the past, with acceptance into his own ego of those identifications which are predominantly useful to him, and relinquishment of those which have proved unuseful or pathological. He shows a similar capacity for forming, or rejecting, part-identifications with figures in current life, including the therapist. This process is well described in some of Erikson's (1956) words about identity formation, where he says that this '. . . arises from the selective repudiation and mutual assimilation of childhood identifications, and their absorption in a new configuration . . .'

The patient now evidences increasingly, not only in therapeutic sessions but in his daily life, the demeanour of a healthy child or adolescent; he belatedly evidences, that is, those normal developmental phases which, because of the severity and early onset of the schizophrenogenic personality-warp, he had barely known in his biological childhood and adolescence. From a childhood which earlier in therapy he had experienced as unrelievedly black, he now remembers, with powerful affects of love and grief, positive experiences with his parents and other figures in his childhood, and there is a consequent freeing-up of useful identifications with those persons' strengths. Thus the strength which helps him to become well derives not only from his positive identifications with the therapist and other figures from current life in the hospital; there is also, and most importantly, this ingredient of his making contact with the strengths in his own past.

To an extent far greater than in the neurotic, however, the patient is likely for at least several months to present himself–and no doubt genuinely to feel–as a naïve little child who doesn't know anything, and who therefore needs to be taught all over again, and correctly this time, how to live. The therapist, aware that so much of what the child learned from family members was indeed pathological and that a high degree of social isolation outside the family prevented his learning innumerable things about everyday life which were common currency among his age-mates, will be under extraordinary pressure to assume the function of a teacher or counsellor. I believe that the patient may benefit from, or at least not be greatly harmed by, the therapist's assuming such a function on occasion. But the therapist rapidly finds himself, here, on thin ice, in danger of losing touch with the only consistently solid function he has in the patient's life–that of psychotherapist. The words of Spitz (1959) concerning psychoanalysis are forcefully applicable here, and the therapist will do well to recall them:

> The essence of psychoanalytic treatment is that it does not direct, advise, educate. It liberates the personality and permits it to make its own adjustments. . . . No directive or educative measures in the commonly accepted sense of the terms are necessary. Indeed, they can only disturb the natural process, which is so highly individualistic as to make it impossible for the particular therapist to direct it in its minute details. Any direction required is provided actually by the transference situation. This insures a process of developmental unfolding free from the anxieties, perils, threats of the original situation.

The patient has been exposed in actuality, prior to the psychotherapy, to more of adult-life experience than he as yet realizes, and the naïve-child orientation is eventually seen in retrospect to have represented a powerful though unconscious striving to keep the therapist enshrined as an omniscient parent, while himself avoiding the fulness of his childhood disillusionment with the parent(s) and avoiding, thus, the responsibility for his own going on to adulthood. If the therapist persists in adhering to his psychotherapeutic function, the next unfolding of the transference consists, in my experience, in the patient's deeply disillusioned and scornful conviction that the therapist is in no measure qualified to be an omniscient general manager of

the patient's life but is, quite the contrary, crazy. This is the development which Hill (1955) evidently had in mind in describing the schizophrenic patient's experience of the conclusion of therapy:

> . . . one hears very little about gratitude from these patients. What happens is that, in the process of taking in the goodness [i.e. identifying with the good qualities of the doctor] and incorporating it actually into himself, the patient manages to make the sort of split that is comfortable to all of us. He is good, and the badness is left with the doctor. Even the illness is left with the doctor. Sometimes it is quite striking that the patient comes to believe that the doctor is thoroughly psychotic, quite in the fashion in which he himself has been psychotic.

This is a very regular development in my work with patients, as I have reported in chapter 8; but, unlike Hill, I feel it essential for the patient's future welfare that the psychotherapy be pursued far beyond this point, until the craziness has been well resolved, rather than simply left in this projected form upon the therapist. It is subsequent to this that there is a differentiation, in the transference, of those intense affects–murderousness, envy, loneliness, fear, and above all deeply denied love (cf. ch. 7)–which lay behind the parents' craziness. The added ego-strength which the patient has acquired in the course of his psychotherapy enables him to experience de-repressed feeling along these paths with a clarity of delineation, and depth of intensity, which he could not subjectively experience previously–no matter how intense were the affects which he acted out during the phase of ambivalent symbiosis. And the therapist is unprecedentedly free now to experience within himself, and on crucial occasions to express, the reciprocal feelings inherent in these transference positions in which he finds himself, with a minimum of the conflict and guilt which had been so prevalent during the ambivalently symbiotic phase.

It is during this late phase of the therapy that the onset of the patient's psychosis becomes clarified; he is finally able to experience, and integrate, the emotions which at that much earlier date had had to be repressed, and defended against by the advent of psychosis. For example, I have had the experience, at once fulfilling and somehow awesome, of finding that a patient who had become schizophrenic at the age of fifteen and had

spent nineteen years predominantly in mental hospitals, had now reached a point, after ten years of intensive psychotherapy with me, where the secondary elaborations of her hebephrenic illness had been sufficiently unravelled for the material of her original delusions to be now coming to the fore, but in a way progressively understandable to both of us.

As the patient makes emotional contact with the various previously repressed areas of his past experience, bit by bit, he eventually reaches the realization that, despite all the years of illness, as one patient expressed it with great relief, 'I'm still myself'. In other words, there is eventually established a sense of continuity of identity, combining the person he felt himself to be prior to the psychosis with the emotions and attitudes manifested in the psychosis, long unacceptable to the conscious ego, but now accepted as a part of it. It is on the basis of such a newly achieved ego strength and such a firmer sense of personal identity that he is now able to take his stand and assess the personalities of figures from present and past life. I remember how impressed I was with one schizophrenic woman, for example, when after three years of therapy she became able to express, in a single breath, her realistic disapproval of certain qualities in her mother, in her father, and in me. Earlier in our work she had possessed far too little of a sense of individuality to be able to objectify these three so important figures, so clearly and simultaneously. She became, as do other patients in the late phase of the work, able to express admiration and fondness equally towards parents and therapist.

Because the therapy of these patients usually requires a considerable number of years, the therapist may find it particularly difficult to be receptive to the expression of some feelings which the patient can face only after several years of treatment. The therapist, keenly aware that, say, five or six or seven years of intensive psychotherapy has elapsed, may feel threatened and therefore impatient at the patient's finally becoming able to explore the depths of the latter's discouragement and despair, or –as I mentioned before–wish for a different parent in the transference, or regressive strivings. It is only through the therapist's being fully aware of the therapeutic progress represented by the patient's becoming conscious of these feelings, and able now to express them verbally rather than having to act them out as in

the foregoing years of the treatment, that he is able to help the patient on towards completion of the therapeutic investigation, rather than towards a re-repression of these feelings for an indefinite time longer.

Similarly, because the therapist has seen the patient to be, earlier in the therapy, such a deeply fragmented person, he tends to retain a lingering impression of the latter's fragility, an impression which may interfere with his going along at the faster pace which the patient, now a very different and far stronger person, is capable of setting. But even this memory-image of the fragile patient, carried with the therapist, has a natural function in the course of the psychotherapy, for it is only very late in the work that the patient himself is able to realize how very ill, how very fragile, he indeed once was; until he becomes strong enough to integrate this realization into his self-image, the therapist has to be the bearer of this piece of the patient's identity. This process is analogous to the well-known phenomenon in which each major forward stride in the patient's therapeutic growth is accompanied, or presaged, by the therapist's suddenly seeing in the patient a new and healthier person (see chs. 10, 11); there, too, the impact of the development falls primarily, for a time, upon the therapist rather than the patient. The patient himself, because his sense of identity is still, during the earlier therapeutic phases to which I am referring at the moment, relatively tenuous, is easily overwhelmed–in one patient's words, 'knocked out'–by the realization of the extent to which he is now changed, even though this change be, in our view, a most beneficial and welcome one.

Another characteristic of the late phase–and I am not attempting to describe, here, all such characteristics–is the circumstance that many of the patient's adult strivings may be found more deeply repressed than his infantile strivings. That is, it may well prove easier for the therapist to contemplate (above, ch. 9), and easier for the nursing staff to recognize and at least partially gratify, various of the patient's infantile and small-child oral needs, than to help him face squarely his powerful adult desires, mobilized and given shape in the course of the psychotherapy but still painfully thwarted by reason of his long hospitalization–his desires to marry and procreate and bear adult responsibilities. Sometimes the patient's expression of such desires, particularly

if he or she has been so long hospitalized that many of these must be accepted as losses or deprivations which can never be made up, is at least as poignant for the therapist to hear as were the earlier-expressed yearnings for infantile and childlike gratifications. He realizes to what an extent, for probably many months now, it is the more *mature* areas of the patient's personality which have been the more deeply repressed ones (ch. 12), and that, in contrast to some of the views expressed by Freud (1915*b*), the maturation process is so deep-reaching that it leaves no changeless core of the personality, no eternally infantile id, unchanged by it.

The evolution of the reality-relatedness between patient and therapist, over the course of the psychotherapy, is something which, so far as I know, has received little more than passing mention in the literature (ch. 15 above). Hoedemaker (1955), in a paper concerning the therapeutic process in the treatment of schizophrenia, stresses the importance of the schizophrenic patient's forming healthy identifications with the therapist, and Loewald (1960*a*), in his paper concerning the therapeutic action of psycho-analysis in general, repeatedly emphasizes the importance of the real relationship between patient and analyst, but only in the following passage alludes to the evolution, the growth, of this relationship over the course of treatment:

> . . . Where repression is lifted and unconscious and preconscious are again in communication, infantile object and contemporary object may be united into one–a truly new object as both unconscious and preconscious are changed by their mutual communication. The object which helps to bring this about in therapy, the analyst, mediates this union. . . .

It has been my distinct impression that the patient's remembrance of new areas of his past–his manifestation of newly de-repressed transference reactions to the therapist–occurs only hand in hand with the reaching of comparable areas of feeling in the evolving reality-relatedness between patient and therapist (ch. 7). For example, he does not come to experience fond memories of his mother until the reality-relatedness between himself and the therapist has reached the point where the feeling between them has become, in reality, predominantly positive. Loewald's words, quoted above, imply to me that an increment

of transference resolution slightly antedates, and makes possible, the forming of each successive increment in the evolving reality-relationship between patient and analyst. It has been my impression, by contrast, that the evolution of the reality-relatedness proceeds always a bit ahead of, and makes possible, the progressive evolution and resolution of the transference, although to be sure the latter, in so far as it frees psychological energy and makes it available for reality-relatedness, helps greatly to consolidate the ground just taken over by the advancing reality-relationship. Loewald (1960*a*) thinks of it that

> . . . The patient can dare to take the plunge into the regressive crises of the transference neurosis which brings him face to face again with his childhood anxieties and conflicts, *if* he can hold on to the potentiality of a new object-relationship, represented by the analyst.

But it seems to me that this new object-relationship is more than a potentiality, to be realized with comparative suddenness, and *in toto*, towards the end of the treatment with the resolution of the transference. Rather it is, it has seemed to me, constantly there, being built up bit by bit, just ahead of the likewise evolving transference relationship. Pertinent here is Freud's (1922) having pointed out that projection–which is, after all, so major an aspect of transference–is directed not 'into the sky, so to speak, where there is nothing of the sort already', but rather on to a person who provides some reality-basis for the projection.

In the final months of the therapy, the therapist clearly sees the extent to which the patient's transferences to him as representing a succession of figures from the latter's earlier years have all been in the service of the patient's unconsciously shying away, to a successively decreasing extent, from experiencing the full and complex reality of the immediate relatedness with the therapist in the present. The patient at last comes to realize that the relationship with a single other human being–in this instance, the therapist–is so rich as to comprise all these earlier relationships, so rich as to evoke all the myriad feelings which had been parcelled out and crystallized, heretofore, in the transferences which have now been resolved. This is a process most beautifully described by the Swiss novelist Hermann Hesse (1951) winner of the Nobel Prize in 1946, in his little novel, *Siddhartha*. The protagonist, in a lifelong quest for the ultimate

answer to the enigma of man's role on earth, finally discovers in the face of his beloved friend all the myriad persons, things, and events which he has known, but incoherently before, during the vicissitudes of his many years of searching.

It is thus that the patient, schizophrenic or otherwise, becomes at one with himself, in the closing phase of psychotherapy. But although the realization may come to him as a sudden one, it is founded on a reality-relatedness which has been building up all along. Loewald (1960*a*) in his magnificent paper to which my brief references have done less than full justice, suggests, as I mentioned, something of the role which transference resolution plays in the development of this reality-relatedness. I suggest that the evolution of the 'countertransference'–not counter-transference in the classical sense of the therapist's transference to the patient, but rather in the sense of the therapist's emotional reactions to the patient's transference–forms an equally essential contribution to this reality-relatedness. This chapter has been primarily an attempt to describe the evolution of what might be called–in this special sense–the therapist's typical 'counter-transference' to the schizophrenic patient, over the course of successful psychotherapy.

Concluding Remarks

In my attempt to make clear the paramount place which emotions–emotions in the therapist as well as in the patient–hold in the psychotherapy of schizophrenia, I would not wish to leave the impression that the therapist should strive to be immersed continually in a kind of emotional blood-bath. On the contrary, as I described it at the outset, the emotionally charged transference evolution which has been traced here can develop, and run a relatively unimpeded course, only if the therapist is sure enough of his capacities for feeling for his basic emotional orientation to be an investigative, rather than for example a compulsively 'loving', orientation. Moreover, each of these patients–and, I think, this is true to a lesser degree of the neurotic patient also–needs in the course of the therapy to project upon the therapist the subjectively unfeeling, non-human and even inanimate, aspects of himself, and thus to see his therapist, in the transference, as the representative of the parents who were, to the child's view, incapable of human feeling, as has

been the patient himself in his own view (ch. 16 above, and my *The Non-human Environment*). Only by thus re-externalizing his pathogenic introjects can the patient make contact with his own feeling-capacities and come to know, beyond any further doubt, that he is a human being. This aspect of the transference, this aspect of the healthy reworking of very early ego-differentiation, cannot be accomplished unless the therapist is able to be self-accepting while spending hour after hour without finding in himself any particular feeling whatever towards the patient. He must be sufficiently sure of his own humanness to endure for long periods the role, in the patient's transference experience, of an inanimate object, or of some other percept which has not yet become differentiated as a sentient human being.

In the course of writing this, the realization has dawned on me that the therapist recurrently experiences guilt in reaction to the arousal of one or another kind of emotion in himself, during the course of his work with the schizophrenic patient, on the basis of a rekindling of the therapist's infantile omnipotence. Such a temporary regression on the therapist's part, to the level of infantile omnipotence, is his major unconscious defence against the realization, and deep and consistent acceptance, of the fact that not only the patient but he also is in the grip of a process, the therapeutic process, which is comparable in its strength to the maturational *process* in the child–which is, indeed, this same process in a particular context, the context of psychotherapy of the adult schizophrenic person. The more experienced and confident the therapist becomes in this work, the more deeply does he realize that this process is far too powerful for either the patient or himself to be able at all easily to deflect it, consciously and wilfully and singlehandedly, away from the confluent channel which it is tending–with irresistible power, if we can give ourselves up to the current–to form for itself. When the therapist sees this, he realizes how illusory has been his subjective omnipotence, but also how groundless has been his subjective guilt.