

Countertransference and Theoretical Model

My working theoretical model for the treatment of schizophrenic patients includes the following elements.

1. The analyst's own more primitive modes of experience, and of interpersonal relatedness, have not been permanently resolved through his personal analysis and other maturing experiences, but are subject to being revived in the course of his ongoing adult-life experience, and this is indispensably true in his work with schizophrenic patients. His analysis is effective insofar as it has given him ready access to, rather than its having somehow affected, his capacities for primitive feelings of jealousy, fear, rage, symbiotic dependency, and other affective states against which his patient's schizophrenia typically serves to defend the patient from experiencing in awareness.

Mahler's (1968) repeated emphasis upon what the Los Angeles group call "genetically prepared tendencies" is related to her seeming obliviousness of the therapeutic necessity for the analyst to gain access to, and utilize in the treatment of the psychotic patient, his own (i.e., the analyst's) intensely bad-mother identity components.

This paper was originally presented as a discussion of the panel on "The Influence of Theoretical Model on Practice in Treating Schizophrenia," given at the meeting of the American Psychoanalytic Association in New York City on December 1, 1972. It was first published in *Psychotherapy of Schizophrenia*, edited by John G. Gunderson and Loren R. Moshier (New York: Jason Aronson, 1975), pp. 223-228.

Thus Mahler underestimates the degree of interpersonal, intrafamilial trauma the patient has suffered despite a relatively normal genetic endowment. By the same token, she underestimates the degree of personally intended sadistic and murderous trauma that the patient inflicts upon the analyst and evokes, retaliatorily, from the analyst.

2. There is thus some basis in reality for all the patient's "delusional transference" reactions, such as his perceiving the analyst as being the personification of the patient's ego-fragmented mother, or emotionally remote father, or whatever. The analyst's working in implicit acknowledgment of these nuclei of reality perceptions in the transference—rather than maintaining relentlessly an assumption that the patient embodies all the disturbingly intense ambivalence, for example, in the treatment situation—is necessary to the patient's developing a better integrated and more comprehensive reality relatedness.

3. A healthier reindividuation on the patient's part requires an experience of therapeutic symbiosis in which the analyst participates at a feeling-level, although to a manageable degree, subject always to his own analytic scrutiny, and quite different in nature from an acted-out *folie à deux*.

4. The patient's own therapeutic strivings toward the analyst, including the patient's guilt- and grief-laden feelings about his having failed to enable the fragmented mother to be a whole and fulfilled mother to him, are of fundamental importance in the therapeutically symbiotic phase of the work.

5. The most basic problem in schizophrenia is the patient's having failed to develop a human identity, either subjectively or, in the more severe and chronic cases, objectively as well. It is in the phase of therapeutic symbiosis that a process of mutual rehumanization, as well as reindividuation, is enabled to occur, through the therapeutic relationship's having become sufficiently strong to enable both participants to let come into play, in the ongoing exploration of the transference, subjectively nonhuman identity ingredients which heretofore had been split off from awareness and acted out in behavior.

Those analysts who view schizophrenia predominantly as a deficiency disease are typically needful of maintaining under repression the bad-mother components of their own identities, and of seeking to reaffirm, in their attemptedly warm and giving approach to the schizophrenic patient, their own good-mother aspects. They are in effect asking the patient to rescue them from their own feared bad-self, or bad-mother introjects.

The paper presented by Dr. Holzman (1975), although largely identical with the version sent to me, has been changed as regards some of the points upon which my prepared remarks are based. In my comments, therefore, I shall be quoting passages from the earlier version.

I, like the members of Dr. Holzman's group, have my own differences with classical analysis. Further, I have known at first hand the value, for therapy and research, of the family approach. I have seen phenothiazines, when used in a moderate and well-timed fashion, facilitate analytic therapy, although I do not employ them. In addition, I regard general systems theory as an exciting and promising new field of scientific thought.

Nonetheless, I find the Holzman paper both dangerous and disturbing. It is dangerous because, in the midst of repeated and incontestable appeals for open-mindedness, it would set schizophrenic persons apart, qualitatively and indelibly, from their fellow human beings as, in their very essence, something less than human. The paper's aura of high-sounding, up-to-date scientific versatility evokes feelings of inferiority and self-doubt in the reader who is committed to an essentially psychoanalytic endeavor, and who well knows that he has reason for humility.

Where I think of the phases of treatment in terms of patient-analyst interaction, Dr. Kayton (1975), however interestingly, conceptualizes them in terms of the patient's inner experience. It is significant that this paper, which states that "During the last two decades . . . progress has come principally from sources outside the psychoanalytic consulting room," says nothing about the analyst's own inner experience of the work. My approach focuses, by contrast, upon the countertransference realm, in the broadest sense of

that term, as being of the greatest and most reliable research and therapeutic value. This focus is not intended as a means of providing narcissistic gratification to the analyst-researcher; quite to the contrary, his personality and especially his sense of identity is found, in one practitioner after another, to be a most sensitive and reliably informative scientific instrument providing data as to what is transpiring, often in areas not verbally articulable by the patient, in the treatment situation.

In my monograph on the nonhuman environment (1960) and in a number of subsequent papers, I have described the necessity of the analyst's helping the patient to become established as both subjectively and objectively human, and of the analyst's becoming able, in this process, to tolerate and even to enjoy, various "nonhuman" transference positions, positions which are experienced by him at first as a frightening threat to his own subjective humanness.

Dr. Holzman (1975) would have us join him and his colleagues in taking flight from the necessary and unremitting exploration of the so-called countertransference dimension of the intensive psychoanalytic treatment of the schizophrenic person and, to the psychiatrist's own relief, taking refuge in relegating the patient to a supposedly separate realm of existence, a qualitatively not-quite-human realm, a realm beyond the psychiatrist's human empathy. I strongly surmise that, when the therapeutic interaction starts to evoke subjectively nonhuman aspects of these analysts' identities, they would turn relatively quickly to the latest information from such scientific fields as behavior genetics, biochemistry, psychopharmacology, epidemiology, and so on, to find reassuring evidence that the schizophrenic patient is, after all, qualitatively different from truly human beings—so that it is pointless to risk one's own going insane by persisting in this disturbingly conflict-ridden effort to work psychoanalytically with him.

The version of the Holzman paper I received contained, for example, this passage: "Some questions thus suggest themselves: (1) Do psychotherapeutic interventions require as intensive a schedule as does psychoanalysis with nonpsychotic patients? (2) Can the same psychotherapeutic effects be achieved by paraprofessional people or

even by groups of patients themselves? (3) Does the mere stable presence of other interested persons provide the necessary support for helping to order the internal disorder and thus to help restoration?" Now, each of these questions has some worth in itself; but, taken together, they are the kind of things said in this paper which, to me, seem to be a downgrading of schizophrenic patients.

Psychoanalysts are essentially the only group of therapists who, by reason of their commitment to a courageous and unceasing exploration of their own inner lives in the service of their treating of their patients, are equipped to discern, explore, and rescue the components of common humanity in the patient who is overwhelmed by a schizophrenic illness which, to less informed eyes, marks him as essentially nonhuman. The estimated 47 percent of all mental hospital patients who suffer from schizophrenia are there, many of them for decade after decade, not only because they have written off their fellow human beings as not kin to them, but also because their fellow human beings have come to accept this as functionally true. If the psychoanalytic movement itself takes refuge in what I regard essentially as a phenothiazine and genetics flight from this problem, then the long dark night of the soul will have been ushered in, not only for these vast numbers of schizophrenic patients—for the current ones who are already largely lost, and for the multitude who will follow them in the future—and for those relatively few psychoanalysts who are particularly interested in this field. It will also have been ushered in for the profession of psychoanalysis generally, and for the patients, generally borderline and neurotic and so on, whom psychoanalysts treat. For once we give up our heretofore unrelenting, open-mindedly observational effort to discern, through an empathic exploration of our own so-called countertransference responses to our patient, the human essence in him which is struggling against the psychopathology besetting his humanness, there is no end to this flight on our part.

The Holzman group says that "Neurosis and schizophrenia are . . . to be conceived of not as a continuum, but schizophrenic and neurotic behaviors are uniquely different." I find this so-called unique difference to be explicable and resolvable in terms of very

primitive, preindividuation, and even presymbiotic, processes—described by Mahler (1968) and others—which all human beings, including those suffering from schizophrenia, share in common, as can be discovered, with reliable repetitiveness, if we remain sufficiently open-mindedly observational of the so-called countertransference realm of clinical phenomena.

Dr. Stierlin's (1975) thoughtful paper contains many theoretical points that I find stimulating and worthy of prolonged clinical evaluation. He beautifully shows that the parents' attemptedly expelling push upon the patient does not imply real separation, but a tragic boundness. But I suggest that for a genuine loosening to occur, the binding first must develop in the transference, in what I call a "pathogenic symbiosis," so that the analyst can know both its gratifications as well as its frustrations and terrors, at first hand. This stage must occur before this mode of transference relatedness can become resolved into that which I term "therapeutic symbiosis," from which a healthier individuation can emerge.

Despite his saying that the children mold and influence their parents as much as the latter mold and influence them, and despite his saying that the therapist can empathically share the plight of the parents as victimized victimizers, Dr. Stierlin's paper is marred, nonetheless, by a recurrent note of blamingness toward the parents as being responsible for the child's schizophrenia. When he speaks of the parents as impressing their own stronger reality upon the child—a view which inherently would attribute to the parents a predominant responsibility for the child's schizophrenia—he takes either no, or too little, account of the following factors.

First, the parents' transferences to the child are such that he, little though he is, is perceived unconsciously as far more powerful than they. Second, the child derives enormous sadistic gratification from the position of being afflicted with schizophrenia for which the parents are held guiltily responsible. Third, as I mentioned earlier and as I have come to see only in recent years, the child himself has a deeply repressed sense of grief as well as guilt, in part reality-based, for his own failure in a predominantly loving effort to enable the fragmented mother, for example, to function as a

whole and fulfilled mother to him. In resorting to a blaming of the parents, we underestimate not only their loving components but the child's also, and shield ourselves from the tragedy which has overwhelmed all of them.

We should not place upon the parents an onus of responsibility we are unwilling genuinely to look for in ourselves as well as in the patients. Repeatedly I have found that, when such emotions as hate, cruelty, rejectingness, and condemnation in myself and in the patient are too intense to be endured, it is momentarily alleviating, indeed, to conjure up images of the patient's parents as being—from however long ago and far away—the persecutors who are making the *immediate* situation so intolerable, rather than maintaining subjective responsibility for my own sadism, for example, and holding the patient responsible for his identifications with the parental aggressors of long ago. The analyst needs, during these stressful times, all his emotional powers at his command; nothing less will do. To displace or project upon the parents the sharpest intensity of, for instance, one's condemnatory feelings toward the patient, is equivalent to tying one's own hands. Such theoretical reasoning provides one with a rationalization for deferring an utterly essential experience of coming fully to grips with the schizophrenic patient.