12. The Schizophrenic's Vulnerability to the Therapist's Unconscious Processes

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After several years of doing intensive psychotherapy with schizophrenic patients, I began to realize that schizophrenic experience and behavior consists, surprisingly frequently, in the patient's responding to other persons' unconscious processes. I had long been aware of the tremendous importance of *projection* in these patient's illnesses; but I was slower to see the great—perhaps equally tremendous—part that *introjection* plays, too, in schizophrenia and, hence, in the psychotherapy of schizophrenia. On theoretical grounds one can readily think, concerning any patient whose ego-boundaries are so incomplete as to facilitate massive projection, that by the same token he will be profoundly susceptible, also, to introjection. But in actual clinical work, introjection is a process that is in most instances much more subtle, much less conspicuously displayed, than is projection, and its detection in the arena of the therapeutic relationship tends to call for a higher degree of self-awareness in the therapist than the noticing of the patient's projection generally requires.

The schizophrenic patient's so-frequent delusion of being magically "influenced" by outside forces (radar, electricity, or whatnot) is rooted partially in the fact of his responding to unconscious processes in persons about him —persons who, being unaware of these processes, will not and can not help him to realize that the "influence" comes from a non-magical, interpersonal source.

For two reasons I shall limit this study to an examination of the impact of the *therapist's* unconscious impulses and attitudes upon the schizophrenic patient. First, it is in the setting of the therapeutic relationship that I as a therapist have had my best opportunities to see this mechanism operating. Second, no matter how greatly this mechanism pervades a patient's relationships with all other persons, it must be regarded as having especially crucial significance when it occurs in the therapeutic relationship, both because this

relationship is of unparalleled importance in the patient's current experience, and because it is essential that the therapist, and eventually the patient, become as aware as possible of the forces at work in their therapeutic investigation. The potential influence, for good or ill, of the therapist's personality upon the schizophrenic patient is even more awesome than that of the analyst in relation to the neurotic patient; hence it is especially incumbent upon the therapist, here, to be as fully aware as possible of the processes at work in him, and of their impact upon the patient.

I shall not attempt to trace out the presumable countertransference element in these unconscious processes in the therapist; rather, I wish only to show various of the *effects* that they have upon the patient's subjective experience and outward behavior. The data I shall present derive solely from the psychotherapy of schizophrenia; but my experience with non-schizophrenic patients has led me to surmise that the relatively dramatic phenomena to be presented here have analogues, less dramatic and less easily detectable but of much importance nonetheless, in other varieties of psychiatric illness. In short, I surmise that it is in the *therapist's* relationship with a *schizophrenic* patient that he can see most readily certain introjective processes that are actually at work, in some form or other, in *any* relationship involving a patient with any type of neurotic or psychotic illness.

SURVEY OF RELEVANT LITERATURE

In psychoanalytic literature, it is in papers concerning countertransference, of course, that the analyst's unconscious processes have been described, and in actuality this whole vast segment of the literature is relevant to my present subject, a segment that had its historical point of origin in a paper by Freud (8) in 1910, in which he wrote, "We have begun to consider the 'countertransference', which arises in the physician as a result of the patient's influence on his unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome this countertransference in himself."

From the subsequent flow of papers concerning countertransference in the analysis of neurotic patients, three recent articles are of greatest relevance here. In 1951, Little (14) noted that "unconsciously we may exploit a patient's illness for our own purposes, both libidinal and aggressive, and he will quickly respond to this."

In 1957, Schroff (16) gave an account of the analysis of a man with a

character disorder of which sexual acting out was a prominent feature. He mentioned that, during a period of treatment with an earlier therapist, the man had acted out some of the therapist's unconscious impulses; and Schroff found, in his own work with the patient, that his countertransference problems influenced unfavorably the man's acting out, until late in the eventually successful analysis. This kind of mechanism, incidentally, had been described in a paper in 1952 by Johnson and Szurek (12), in which these authors reported their finding of children's acting out the parents' unconscious antisocial impulses. Barchilon (3), in a paper in 1957 concerning "countertransference cures," reported a number of examples of analytic "cures" that he showed to be based precariously upon not only transference but also countertransference, and he commented that "in more extreme cases, the therapist forces the patient to act out his own unconscious solutions with little relevance to the patient's needs."

Turning now to the literature concerning schizophrenia, we find many papers that have emphasized the schizophrenic's powerful tendency toward incorporation or introjection:[1] a tendency that renders him vulnerable to the kind of phenomena that I shall describe. A few examples of such papers, concerning incorporation or introjection in schizophrenia, are those by Nunberg (15) in 1921, Abraham (1) in 1927, Bychowski (5) in 1930, and Allen (2) in 1935. In 1945, Fenichel (7) commented that "it is possible to demonstrate in persons suffering from delusions of persecution the presence of the pregenital aim of incorporation which was the undifferentiated forerunner of both love and hate. Projection as such is based on a vagueness of the borderline between ego and nonego. Ideas of incorporation also correspond to this vagueness. The incorporated object has become a part of the subject's ego."

Hill (10) in 1955, in his volume, *Psychotherapeutic Intervention in Schizophrenia,* described the parent's unconscious as playing an integral role in the development of schizophrenia in the child. Hill stressed the etiological importance of what one might call the introjection, into the child's superego, of the mother whose own personality-integration is under severe assault from her unconscious affects: "[The patient's] life has been severely restricted, limited, and invaded by the requirements of his parents' conscious and unconscious conflicts and drives. Anything in the unconscious of the parent which would produce anxiety must become a preoccupation of the patient in order to keep down parental anxiety and thereby reduce his own distress."[2]

"One meaning of the futility of the dependence-independence struggle of

the schizophrenic . . . is his belief, based upon his observations, that, if he should improve and become well . . . his mother would become psychotic."[3]

Concerning "the mother as a presence in the superego" of the patient: "His superego is to him a very real person within him, who not only advises and threatens or opposes but actually dominates his life with crippling restrictions and interdictions supported by the threat that the superego itself will go crazy."[4]

"There is danger constantly of invasion of primitive superego demands which will disorganize the ego into a psychosis."[5]

Limentani (13), in a paper in 1956 concerning symbiotic identification in schizophrenia, made, in passing, the following reference to a patient's sensitivity to his therapist's unconscious processes: "Richard was so keenly aware of his therapist's mood and reproduced it so closely that the therapist at times gained, from the interviews with the patient, awareness of how he himself felt."

Also in 1956, Bowen (4), in a preliminary report concerning his findings in a research project involving concomitant psychotherapy of schizophrenic patients and their parents, with the latter being housed on the hospital ward with their children, likewise portrayed the schizophrenic's vulnerability to the parent's unconscious affects: "The more we have worked with these family groups at close range, the more we can see the interchangeability of anxiety and symptoms. When we hear a mother express a worry about something that is outside the local setting, and when we get some feel of the intensity of the mother's worry with no expression of the worry in the mother, but at the very same time we see the patient's psychosis increase, it makes us more and more inclined to believe that schizophrenia is a process that exists within the family constellation rather than a problem in the patient alone."

In a paper in 1951 concerning various manifestations of incorporation (which I am here terming *introjection*) in the therapeutic relationship, I described a number of instances in which mutual incorporation was found to be present; one of these examples was from my work with a schizophrenic patient (17). In a paper in 1955 I pointed out that the schizophrenic's fear that he will lose his identity if he comes too close, emotionally, to another person, is a realistic fear insofar as he utilizes the mechanism of unconscious identification with (i.e. introjection of) the other person as a means of keeping out of awareness the anxiety-laden affects that interpersonal close-

ness stimulates in him (18). And in a paper in 1957 I presented the concept that one significant factor in the causation, and maintenance, of schizophrenia in any given individual consists in the impact upon him of other persons' efforts—largely or wholly unconscious efforts—to drive him "crazy." In support of this concept I presented data from patients' intrafamilial relationships, ward-group relationships, and intensive pychotherapeutic relationships; and I reported the finding that the motivation of the other person, who integrates with the patient in such a fashion, seems most often to consist in an unconscious desire to maintain a symbiotic relatedness with him (20).

CLINICAL MATERIAL

There now follow clinical data illustrative of three different ways in which a patient may respond to the therapist's unconscious processes. The patient may *(a)* experience the therapist's unconscious processes as being facets of his own personality or *(b)* experience them in the form of hallucinations or *(c)* compulsively act them out in behavior that he himself finds incomprehensible.

The Patient's Experiencing the Therapist's Unconscious Processes as Being Facets of His Own Personality

In illustrating this first phenomenon material from only one therapist-patient relationship will be presented, because it is essentially the same phenomenon, I think, as that which one finds so commonly and characteristically in depressive states. I present it here solely because I have realized only recently how frequently this can be detected among schizophrenic patients also. With these latter patients, *projection* is so conspicuous that one may fail to detect the more subtle, but perhaps equally important, place of this type of *introjection* among the patient's psychotic defenses.

Three months ago I began working with a twenty-six–year–old schizophrenic woman whose previous therapist had left the Chestnut Lodge staff. I had seen this woman, in passing, innumerable times in the course of her several years' stay here, and had always thought of her behavior as outstandingly dominated by paranoid projection. She made almost incessant accusations, to myself and other passers-by, of this sort: "I know what you're thinking! You're thinking that I shouldn't have drunk that coffee at 2 P.M. yesterday," or "I know what you're going to say—you're going to say that

I should have visited longer with my aunt over the telephone last week." She would go, actually, into endless detail, and with innumerable variations, quite unwittingly displaying before the public eye the most private areas of her own unconscious, in this projected form. And in her psychotherapy with my predecessor, she evidenced projection in a similarly prominent fashion, as I learned from him in my capacity as supervisor during about eighteen months of their work together.

It therefore came as a great surprise to me, when I began having therapeutic sessions with her, to find that although her long-known projection continued to be prominent, there were fascinatingly subtle evidences that introjection was at work with something like equal frequency.

Thus far in the work with her I have not found this operative with respect to truly *unconscious* processes in myself, the kind of processes with which this paper is especially concerned, although I have little doubt that the future course of our work will bring to light such connections. What I have found, rather, have been dozens of evidences of her introjecting aspects of myself that were preconscious in me at the moment and readily accessible to my consciousness. Had they not been so, I could not so quickly have discerned the fact of her introjecting them.

For example, in one of the first week's sessions, as she was prattling on in a self-depreciating and rather absent-minded fashion, I took my ease by tilting my head over, at a sharp angle, against the wall. She continued rambling on, but apparently taking in, with her eyes, this shift in my posture; one of the features of her behavior which had impressed me during these early sessions was her apparently taking sharp visual note of every least little thing about my appearance and bodily movements, but never making any verbal comments about these—never expressing any opinions about, or direct reactions to, them. In this instance, what I heard within a few seconds, in the midst of her prattling, was, "I know I looked awkward on the tennis court," whereupon it occurred to me that this unusual, head-tilted posture of mine might well look awkward to her. In another session soon thereafter, the day was so hot that I removed my coat and loosened my tie; within a few seconds I heard, in the midst of her self-critical prattle, the statement, "I'm a very slovenly person." Thereupon I realized that in the eyes of this woman who had come from a highly genteel background and even in her illness was generally neatly groomed, I might well appear slovenly, sitting there in shirt sleeves and loosened necktie. But the fascinating thing was that she evidently genuinely experienced these traits as being aspects of herself and was quite

unable to perceive them as traits of mine. I had already heard from her, within these first few hours, enough about her relationships with her parents to surmise that she had had largely to repress any critical feelings experienced toward either of her parents, both being persons with unresilient and defensive character structures, during her upbringing.

One might look at it that, in each of these instances I have described, this woman reacted, in keeping with her low self-esteem and intense self-criticism, to my actions as being non-verbal communications to her, communications designed to convey to her my opinion that she was awkward and slovenly. This would be a quite-true viewpoint, I think, but would not negate the fact of her genuinely introjecting these behavior traits of mine. Incidentally, it should be noted that what she introjected were, apparently, not only my behavior traits themselves, but, even more clearly, my preconsciously *low opinion* of these behavior traits in myself. This I regard as an example of one of the mechanisms by which the schizophrenic patient expresses his unconscious endeavor to relieve the parent's own anxiety—by, namely, introjecting the parent's intrapsychic conflicts.

In subsequent hours, I found her to be referring to herself variously as "smug," "swaggering," "blah," "sleepy," and so on, at times when, I realized after hearing her say each of these things, I was feeling thus and was no doubt appearing thus to her, but so appearing at a level of perception that was unconscious in her. It was evident that at a conscious level she genuinely perceived only *herself* as being thus-and-so, as, to be sure, she indeed was at times; but she seemed quite unable to perceive, consciously, that *I too* was being smug (or whatnot), and being so, oftentimes, when she showed nothing in her demeanor that would warrant her self-accusation along this line.

Perhaps partly as a result of my perceiving this tendency toward introjection on her part, and my therefore encouraging her to experience, and express, critical feelings to me as these became roused in her by the things I said and did, it required only a few weeks for her to begin expressing annoyance to me about my looking smug, or "blah," or whatnot, at times when I was indeed feeling so. The relative ease with which this introjective mechanism could be relinquished suggests that her perception of these various behavior traits of mine had been taking place at, actually, a preconscious rather than fully unconscious level. And this consideration ties in with my general impression that this particular type of introjective phenomenon, which I have just described, is found in schizophrenic patients whose ego-functioning is at least somewhat more intact than that of the patients who manifest

the other two types of introjective phenomena that I shall illustrate. These latter, more deeply disorganized patients leave one with little doubt that these phenomena are taking place in them at a deeply unconscious level—deepest of all, I believe, as regards the third type of phenomenon to be described.

Before going on to the second type of phenomenon, however, let me call attention to the general point, touched upon at the beginning of this paper, that—as can be seen in the brief data already given—introjective phenomena are less easily perceptible, and their detection calls for a higher degree of self-awareness in the therapist, than is the case with projective phenomena. A simple example will point up this contrast. If a patient looks suspiciously at the therapist and says with hostility, "I know what you're thinking—you're just figuring out a way to kill me!", and if this comes at a time when the therapist has no such thought or feeling in his awareness, he is at once alerted to the possibility that the patient is *projecting* some murderous intent upon him. But if a patient says, instead, with the self-disparagement that one finds so frequently among schizophrenic patients, "I'm just a fat slob who can't even speak English!", it takes a bit of doing for the therapist, who probably at the moment is not having the thought that he himself is a fat slob who doesn't speak English in any outstandingly cultured way, to let his own trend of thought open up to just this rather unpleasantly jolting new reflection: namely, that much as he prefers to view himself otherwise, he *is* somewhat corpulent and his use of grammar *isn't* the best. Not until the therapist has traversed this relatively roundabout and difficult path does the thought occur to him, now, that *introjection* may have been involved in the statement the patient has just made.

The Patient's Experiencing the Therapist's Unconscious Processes in the Form of Hallucinations

Until about one year ago I considered hallucinations to be, without exception, essentially projective phenomena. That is, I found that my clinical experience substantiated the usual textbook descriptions of them as being due to projection. I refer, here, to such descriptions as the following one by Fenichel (7): of hallucinations he says that "Inner factors are projected and experienced as if they were external perceptions."[6]

But in the course of my work with a certain schizophrenic man I discovered that, in at least some instances, to understand why a patient is hallucinating we must see this as having to do with not only *pro*jection but also

*intro*jection. To be specific, in this particular instance I found that the patient's evident hallucinating of murderously threatening figures connoted not only his projecting, in the form of hallucinatory figures, his own unconscious murderous impulses, but connoted also his struggle against the introjection of *my* own unconscious murderous impulses toward him.

A thirty-two–year–old man, he had been hospitalized constantly for nearly ten years (including a five-year stay at another hospital prior to his admission to the Lodge), and had had nearly five years of intensive psychotherapy with a succession of therapists, before I undertook therapy with him. He proved, soon after I had begun seeing him, to be a most intensely frustrating and threatening person. For about two and one-half years his behavior during my sessions with him was limited almost exclusively to *(a)* sitting in slovenly torpor, dropping cigarette ashes on my rug, picking his nose and wiping the yield therefrom upon his trousers, and making no sound except for belches and the extremely frequent and quite unrepentantly loud passage of flatus and *(b)* infrequent vitriolic outbursts at me, in which he would give every evidence of being barely able to restrain himself from attacking me physically, and would say such things as, "You black, slimy son of a bitch! Shut up or I'll knock your teeth out!" As the months wore on, I felt under increasing strain because of his massive resistance to psychotherapy, and increasingly afraid of his tenuously controlled rage. There were many evidences, which need not be detailed here, that his rage was largely dissociated; so I had reason to feel that this man, who outweighed me by at least twenty pounds, had a great deal of rage that neither I, nor he himself, could reliably contain.

Meanwhile, he had evidently begun to respond to hallucinatory voices, both in his daily life on the ward and, at times, during his psychotherapeutic sessions. For several months, he gave every indication, in the content and tone of his responses to them, that these were contemptuous, taunting voices; he would talk back to them in a furiously angry way. Only in retrospect did it occur to me that maybe these hallucinations had some connection with the contempt that had developed in me toward him, contempt that in that phase of our work remained in an unconscious, dissociated state in me, erupting into my awareness only at brief moments with an intensity I found shocking. For example, once when I saw him passing through the far end of the corridor I had a startlingly new thought and feeling, about this man whom I had been consciously regarding predominantly as a desperately suffering, psychotic individual, no matter how discouragingly and frighteningly so. My thought

was, "There goes that crazy son of a bitch!", accompanied by a most intense feeling of contempt toward him.

During still later months in this two–and–one-half–year period, it seemed that the hallucinatory figures to which he frequently responded were predominantly frightening ones; his responses to them were not so much angry as frightenedly defiant, as if he were trying to keep his courage mustered in the face of them. In one of the sessions, while I was feeling, as usual, more intensely "strained" than anything else, I noticed that as he came in and sat down he said to himself in a hushed, quavering, very frightened voice, "Careful!", as if he sensed an ominous presence in the room. It was only a few sessions after this that an incident occurred that showed me how much dissociated rage there had been in me, presumably for a long time, and presumably fostered by my having been laboring under so much discouragement and, still, threat of physical injury for so long. In this particular session to which I now refer, he had been leafing through one of the magazines from a nearby end-table in my office, as he had taken to doing occasionally, with my whole-hearted approval. But after finishing with it he tossed it desultorily toward my couch; it fell short and lay on the floor. At the end of the hour, he left without bothering to pick it up. As he was walking out the door I stooped down to pick up the magazine, still feeling only a sense of great strain. But as I lifted it up I suddenly became overwhelmed with fury, and smashed the magazine down onto the end-table with all my strength, sending a glass ash tray flying. It was at this moment that I realized the probability that he had long been sensing, and responding hallucinatory to, this rage in me, which had been dissociated heretofore.

It required several more months for me to become accustomed to feeling such an intensity of rage toward him; meanwhile, over this several-months' period, this feeling would come into my awareness only fleetingly and then return, presumably, to an unconscious level. One of these subsequent occasions of my momentarily increased awareness involved a magazine again. When, this time, he slung one of my more-prized magazines into a nearby chair, rumpling and tearing it somewhat with the force of the throw, I found myself saying to him in a balefully threatening, even tone, "Go easy on the magazines. You're not in a pig-pen." On another occasion when he had been contributing to the session naught but occasional belches and flatus and a kind of insolently contented appearance, and he now took out a cellophane-wrapped package of crackers and ate them, it was at the point when he nonchalantly tossed the cellophane onto the floor that I found myself filled

with quick fury and said, "Listen!—Don't do that in my office! Don't throw paper on my floor!", at which he looked flustered and immediately picked up the cellophane. On another occasion, when I was discussing his psychotherapy with a number of colleagues in a seminar, telling them that I had recently begun sitting over in a corner away from the door so that he would have ready access to the door in case he became terrified of his murderous rage toward me, I realized that I had been unconsciously maneuvering the seating arrangement so that, in case he attacked me physically, I would now have a legitimate excuse—since I would now be unable to get to the door—to enter into a knock-down-drag-out fist fight with him for which, I now knew, I had been yearning for weeks. And it was within a few days of this time that when someone asked me, at lunch, how this patient was getting along, I found myself grating, "Well, he's alive, and that's not doing badly, considering how I feel toward him.[4]" More than once I had felt lucky to get out of our sessions alive; but I had not realized before that he could be looked upon as being fortunate in this same sense.

The most memorable of these incidents when this usually dissociated rage came into my awareness was when, one night, I dreamed that he and I were fighting, and I was reacting to him as being—as I in waking life was then considering him to be—a dangerous, uncontrollable person. In the course of this dream-struggle he got his hands on a knifelike letter opener. But what then happened, as I was astonished to recall upon awakening, was that *he* took *me* into custody; he, functioning as a kind of sheriff's deputy, was marching me out to turn me over to the authorities when the dream ended. Upon awakening I realized that my chronic fear of his attacking me was based, in part, upon a fear of my own largely dissociated and therefore poorly controlled rage. On the following day this instructive dream yielded good dividends: when, while sitting in an upholstered chair in my office, he suddenly passed flatus of an unusually gurgling sort, I was able to have, with no attendant anxiety, this furious thought, "You son of a bitch, if you shit in that chair I'll massacre you!"

It was both fascinating to me in a research sense, and deeply gratifying to me as a therapist, to find that, by the end of two and one-half years of both his, and my own, becoming more fully and consistently aware of our respective feelings of intense contempt and rage, his hallucinating had now all but disappeared from our sessions together. One way of describing what had happened is to say that my increasing recognition, and acceptance, of my own feelings of contempt and rage toward him served to arm me sufficiently

so that I could step in and interact with him at the furiously vitriolic level at which he had often "interacted" with his hallucinations, previously, while I had sat by, paralyzed with anxiety at the extraordinarily intense rage and contempt his behavior was arousing in me at an unconscious level. I had come to realize that it actually relieved me greatly when he would shunt the most intense portion of his rage, for example, off to one side, toward a hallucinatory figure, and would disclaim that he was having any such feeling toward me. But there came a certain memorable session in which I felt sufficiently furious about what was going on, and sufficiently sure of my ability to meet both my own rage and his, so that I was able to step into the shoes, as it were, of the hallucinatory figure or figures at whom he was directing his greatest fury, and from that day on it was as though there were less and less "need" for these hallucinatory figures in our interaction with one another. What I did, specifically, in that crucial session was to insist, with unyielding fury—despite his enraged threats to assault me—that these vitriolic tirades, such as he had just now been ventilating while denying repeatedly that they were meant for me, were really directed toward me.

Midway in all this long development, it occurred to me that the emotional wavelength, or level of "interaction," upon which he participated with the hallucinatory figure(s) provided me with a clue as to the level at which he needed for *me* as his therapist to be interacting with him; namely, this same level of vitriolic contempt and rage. I still feel that this was true enough, and that this can be looked upon as a valid general principle in one's therapy with a patient who is hallucinating. But during the subsequent months of this development that I have described, I realized in retrospect that I *already had been* participating with him at this emotional level, but had been dissociating my feelings that were invested at this level of interaction.

Subsequent to my experience with this man, I have seen a number of times this same mechanism at work in patients' hallucinatory experiences. I shall mention briefly only two of these additional examples. One of these occurred in the course of my work with a thirty-five–year old–woman suffering from paranoid schizophrenia, a woman who for years—even before I became her therapist—had been indicating, frequently, her involvement in a hallucinatory experience of being raped and impregnated; pregnancy she considered to take place not in the uterus but in the "stomach." I came to see in retrospect, during my own work with her, that this experience of hers bore quite possible correlations with my then-dissociated desires to impregnate her. The likelihood of this came to my attention when the following two events occurred in

close sequence: *(a)* In one of our sessions, in which she was not being her usual antagonistic self, but in which there was, rather, predominantly a feeling-tone in the hour that I experienced as mutual, warm friendliness, with considerable sexual undertones, she suddenly looked anxious and demanded, insistently, "Did you just put something from your stomach into my stomach? *Did* you?" I reacted—correctly, I think—to this question as being equivalent to, "Did you just impregnate me?", and her anxiety was so great that, rather than making an analytically investigative response, I assured her flatly and simply that I had not. *(b)* But only a relatively few nights thereafter, I had a dream in which I was impregnating her. Prior to this I had been unaware of this specific desire toward her, although I had felt many times before, in response to her frequently seductive behavior, an erotic urge in which this specifically reproductive aim did not show itself. I can not, of course, prove that her subjective impregnation experience was indeed in part a reaction to such dissociated desires in myself. But it is my impression that there was such a connection, and I am quite ready to believe that her similar experiences in past years, prior to my own work with her, had involved similar links with dissociated processes in other persons who at that time were important to her.

The third, and final, example is from my supervisory work with a therapist who was undergoing personal analysis and who was seeing me for the supervision of his work with a schizophrenic young man. After the therapy —and likewise the supervision—had been under way for several months, I noticed that two new developments had appeared at approximately the same time. First, the patient began showing, in the therapeutic sessions, clear-cut evidence of hallucinatory experiences; specifically, there were strong suggestions, in the way that the patient giggled in a sexually titillated fashion, and murmured verbal responses in the same vein, that he was experiencing some sexually teasing hallucinatory figure in the room. Second, I noticed that the demeanor of the therapist himself had changed very appreciably; he had previously appeared to me to be a quite sexually repressed person, but now was showing many nonverbal indications of seductiveness. He described, at this time, a single instance of his verbally teasing the patient; but I had the impression that the therapist was quite unaware of the probable erotic element in this teasing. My belief was, and is, that the patient was hallucinatorily responding to not only projected desires-to-sexually-tantalize, but also to similar desires in the therapist, which latter desires were being brought toward the surface, but not yet into conscious awareness, by, I thought most

likely, his personal analysis. Again, I realize that these data fall far short of constituting solid proof for such a hypothesis. But it is my distinct impression that such was the case; in summary, I found the therapist to be evidencing a newly revealed sexually teasing quality toward me, and there were hints that he was evidencing—unwittingly, as seemed to be the case in his relationship with me—a similar quality toward the newly hallucinating patient.

It is valid, I think, to consider any hallucination as a manifestation of some affect, or combination of affects, that is being warded off from acceptance into the individual's conscious ego. Hence it is indeed correct—no matter how curious it may sound—to look upon the above patients' hallucinations, resultant from both their own and their therapists' dissociated feelings, as representing not only a *projection* of certain feelings of the patient's own, but also a struggle against the *introjection* of the therapist's dissociated feelings of this same variety. A paper by Greenson (9) in 1954, entitled "The Struggle Against Identification," provides clinical data that form an interesting comparison with the data I have just been presenting. Greenson's data were derived from neurotic, rather than psychotic, patients and reveal these persons' struggle against identifications with *parents* from the *past,* whereas my material shows the patient's struggle against identifying with—introjecting—the *therapist,* or more specifically certain unconscious elements in the therapist, in the *present.* A sufficiently searching investigation of the transference connections between the present and past in the experience of the patient would, I feel sure, show how integrally related are Greenson's material and my own; but such an inquiry is beyond the scope of this paper.

One last theoretical point should be made before going on to the third and final, clinical category; this is a point that pertains to each of these three categories of clinical phenomena, but it can be seen most clearly, perhaps, in connection with such hallucinatory phenomena as have been described. That is, one may say in general, I think, that an individual must have a relatively healthy ego in order to remain convinced of the reliability of his preceptions of the other person, in the absence of any *consensual validation* from the latter; validation that, if forthcoming, would reassure him that he is indeed perceiving realistically. A therapist, for instance, must possess a relatively healthy ego to be able to carry on his daily work, relying heavily upon his own perceptions of patients in the usually obtaining absence of much corroboration from the patients, corroboration of, for instance, the therapist's perception of preconscious or unconscious hostility, or guilt, or friendliness, or whatnot in the patient. Therapists can, and much of the time in their daily

work do, successfully meet this ego-challenging experience. But the psychotic patient's ego is too weak to meet a similar challenge without his suffering a temporarily increased ego-fragmentation: if he senses that his therapist is murderously inclined, for example, toward him, but if he gets no conscious validation from the therapist that this perception is a correct one, the patient is then likely to experience a hallucination of a murderously inclined figure; since, one might phrase it, the therapist has refused to accept the perception as being truly applicable to himself, as "belonging here upon me."

Acting Out as a Response to, or Vicarious Expression of, The Therapist's Unconscious Processes

For several years I have had the impression that some instances of a patient's acting out may be due partially to the therapist's own unconscious strivings in this same direction; may represent, that is, a vicarious, compulsive expression of, or a response to, the therapist's unconscious desires. Since this general concept has already been described by Schroff (16) and Barchilon (3), and the identical mechanism as taking place in the patient's intrafamilial relationships has been described by Johnson and Szurek (12), Hill (10), Limentani (13), and Bowen (4), I shall give only brief examples of this general mechanism before turning to a more specific type of manifestation of it that, so far as I know, has not been mentioned in the literature.

It was about eight years ago that I discovered evidence, in work with a hebephrenic woman, that the acting out in which one's patient is involved may consist partially in a response to one's own unconscious desires. Relatively early in my work with this woman, she began to evidence, both during her therapeutic sessions and in her daily life on the ward, an intense fear lest she be raped. In the words of her administrative psychiatrist, she was "crawling with terror" in this regard; her life on the ward was largely taken up with her insistently demanding reassurance against this from one and all about her. It was only after several months of this that I became aware, I think very belatedly, of powerful urges to rape her. These urges I found so frighteningly powerful, in fact, that I confided to the Director of Psychotherapy my concern lest I be unable to control them. I might add that he only laughed in mild amusement, a response that I found vaguely belittling; but the life of a director of psychotherapy is doubtless a difficult one. I realized, thus in retrospect, that the patient's anxiety lest she be raped was probably, at least

in part, a response to these powerful, and at that time dissociated, desires in me. There was much data at hand to suggest that her transference to me was predominantly colored by her earlier relationship with her father who, her history strongly indicated, had long struggled against just such unconscious desires toward her.

In later months of my work with her she began evidencing a sexually provocative behavior toward various of the male personnel members, and after this had gone on for many weeks, I gained from my personal analysis the realization that erstwhile-unconscious homosexual desires in myself had been quite possibly a factor in this particular acting out; the realization, that is, that she had been vicariously expressing, in her behavior, my unconscious desires to make sexual overtures to these men. And still later on in her therapy I found various clues pointing toward a connection between, on the one hand, her beginning now to set fires on the ward and, on the other hand, largely dissociated urges of a similar kind on my own part. The group of nurses on her ward at this time reacted to me as being quite directly responsible for the patient's fire setting; on one occasion, for example, when I went up to her ward for the therapeutic session, the charge nurse bluntly let me know this. She met me with an accusing, "Edith just set a fire in one of the wastebaskets," and when I protested, "The way you nurses react to me about this sort of thing, anybody would think *I* had set the fire in the wastebasket!", she retorted, "*Well—?*" Later on, as I became more fully conscious of my own similar desires, and of the very probable influence these desires had had upon this phase of the patient's illness, I realized that the nurses' accusations had not been totally unfounded and unfair.

Now I wish to describe, in greater detail, a specific kind of phenomenon of this same general third sort—a specific kind that, as I mentioned, I have not seen described in the literature, and that has come to my attention within the past three years. This phenomenon consists in the (schizophrenic) patient's evidencing, in the therapeutic session itself, pathological and often puzzlingly grotesque behavior that arises partially from this same source; an acted-out behavioral response to, or expression of, unconscious elements in the therapist.

I first became aware of this "introjective acting out" psychodynamic basis of such grotesque behavior in the course of my work with a deeply ego-fragmented schizophrenic woman, twenty-eight years of age at the time when I became her therapist. During the first two years of our work together, she incessantly manifested a striking variety of bizarre, changing physical pos-

tures; looking thoroughly bewildered and acting as though the sudden and discoordinate movements of her limbs, head, and torso were taking place via a puppeteer's strings quite outside her control. And such verbalizations as she uttered were, for the most part, similarly discoordinate and confusing to, it appeared, herself as well as to the therapist.

Then, over a subsequent period of approximately six months, a series of incidents suggested to me that a considerable portion, at least, of her strange behavior (as strange in her daily ward life as in her sessions with me) rested partially upon the psychodynamics—the combination of introjection and acting out—that I have described.

One of these incidents occurred during a session in which I was sitting, as I often did, slumped far down in a chair and with my knees crossed in a way which, I realized in retrospect, may well have looked grotesque to an observer. But all I was aware of at the time was that I was feeling comfortably seated and that she, in a nearby chair, began muttering something to the effect that "He comes in here and tears off my arms and legs." She then asked me, twice, to put my leg down, which I declined to do. Then, after a considerable interval she half arose and stood with a leg extended before her, awkwardly crooked and unsupported in the air; the leg gave a peculiar impression of dismemberment from the rest of her body. I asked, astounded at this thought, "Is that the way my leg looks to you?" She agreed, convincingly. I think it valid, too, to look upon such an incident in the following terms: she reacted to my assuming a dismembered-looking posture (a posture I had experienced simply as being a comfortable one) as being my way of serving notice upon her that I intended to dismember her. But I am quite ready to believe, in terms of my long experience with this unusually deeply ill woman, that she may indeed have felt dismembered on the basis of an introjective reaction to my grotesque posture.

My better judgment tells me that, as regards the communicational facet of this incident, what she was responding to, in me, were unconscious desires to dismember her, desires my posture betrayed; but this I can only conjecture, for I have not recognized such desires toward her in our still-continuing work. I have clearly discerned such desires on her part, and have no doubt that *projection,* as well as introjection, was playing a part in this incident as in all these other incidents I have been describing.

By the time this phase in our work had been reached, the patient was now able, as the above material shows, *consciously to let me know* that her bizarre posture was a response to her perception of my own posture. But by now her

air of bewilderment had greatly diminished, as had her grosteque and dissociated-looking physical movements. My belief is that in this earlier, two-year phase, when her ego-functioning had been clearly more profoundly impaired, she herself had been quite unable to realize that the puzzling movements of her body had any connection with her perceptions of my own movements.

On subsequent occasions she was able to let me know, similarly, that her assuming the posture of a model on a surfboard was her way of showing me how I, draped narcissistically, I now realized, in my chair, appeared to her; and that her (now only occasional) use of verbal gibberish was a representation of the way my own speech often sounded to her. For years she had plucked hair from her scalp and had picked her clothing to pieces, and now, in one of the sessions, as she went through the gestures of pulling the flesh of her hands to pieces, she communicated to me the point that she experienced me as picking and pulling her, with horrifying cruelty, into pieces. In each of these instances, I was able, with deep dismay at times, to find a kernel of reality in her perceiving me thus. And when late in one of our sessions I saw a horrid grimace, a grotesquely taut kind of diabolical smile, slowly come over her face as if of its own accord, I was at first baffled, and then reached the jolting realization that this "smile" was a representation of the way in which a hypocritical, forced, and undoubtedly rather cruel, smile I had turned on, early in this session, had appeared to her.

In most such instances—and I have found many like examples in my own work with other patients, and in my supervision of other therapists' work with their schizophrenic patients—the patient's response is such a grossly exaggerated caricature of the therapist's actual behavior as to add to the therapist's unreadiness to recognize this connection. That is, the therapist is hampered not only by the fact that he has been manifesting something that he would prefer not to find in himself, but also by the fact of the patient's portraying this in so extremely exaggerated a form. Here it must be remembered that the patient's perception is grossly warped by the factors of both projection and transference. But it is very important for the therapist to be able to recognize the nucleus of *reality* perception that lies in the patient's response, for it is by encouraging the growth of such fragments of reality-relatedness that he can be of greatest value to these deeply ill patients.

I shall mention only a second and brief example of this same phenomenon before proceeding to discussion. This example is from my work with the thirty-two–year–old schizophrenic man whose hallucinatory phenomena were described at length in the preceding clinical material. This incident occurred

during that phase of our work in which intense rage and contempt toward him had developed within me, but had not yet come fully into my awareness. At the end of one of the very-many sessions throughout which he had remained mute save for belching and the passage of flatus, I said, with forced "friendliness" and "politeness," "Well, the time's up for today." To this he responded with a growlingly hostile, dissociated-sounding, "Go to hell, you son of a bitch!" I recognized this, later on, as constituting not only a presumable expression of the way he felt toward me, but also a quite accurate expression of my own genuine, but repressed or at least heavily suppressed, feeling of rejectingness toward him at this moment.

Eissler (6), in a paper in 1943, made a comment that is relevant to this last-mentioned clinical incident: "The . . . [therapist's] communication, so far as it is verbal, will frequently contain more aggression than the schizophrenic's sensitivity can stand. Actually language contains innumerable terms which have changed their original meaning, so far as they have lost their primary connotations of local or physical reference in favor of a more spiritual meaning. The background of the schizophrenic's language regresses to those original meanings of a cruder, even brutal coloring. Hence, ordinary language tends to hurt the schizophrenic."

But, evidently unlike Eissler, I do not believe that it is simply that the schizophrenic *reads into* the content of the therapist's words an archaic meaning, a brutal meaning that is not at all resident there in actuality. I believe, rather, that here again there is a kernel of reality in the schizophrenic's response; there is genuinely conveyed by the words, in such instances, brutality that is present in the therapist's unconscious, no matter how greatly the patient's response is exaggerated through such mechanisms as projection and transference.

DISCUSSION

This paper does not represent an effort to describe all possible types of introjective manifestations that schizophrenic patients exhibit, but rather to describe only those having to do with *unconscious* processes in the *therapist.* One sometimes finds, for example, a patient expressing the conviction that persons whom he knows or has known in the past, are literally inside him now—in his stomach or in his leg or his foot, or whatnot; or he may be convinced that his bodily parts are those of some other individual.[7] But such material is outside the scope of this particular study.

And I do not mean to imply that the patient introjects only those processes in the therapist that are *unconscious,* or preconscious, in the latter. I surmise that it is indeed such processes in the therapist, or some other person, that the schizophrenic patient is more prone to introjecting, than is the case with the other person's *conscious* affects and ideation—for the reason, having to do with the absence or presence of consensual validation, mentioned earlier. But I consider this particular facet of the matter to be, likewise, beyond the focus of my effort here.

A third point is already implied in this paper, and needs to be made explicit only briefly: the *therapist* not uncommonly has introjective experiences vis-à-vis the *patient.* In my own sessions with schizophrenic patients. I have had, not infrequently, feelings and fantasies that seemed distinctly alien to my usual experience, that I experienced as foreign bodies in my consciousness, and that I regard as instances of introjection on the part of the therapist. And I have heard, many times, fellow therapists describe similar experiences.

This, in turn, brings up the therapeutically *constructive* side of this whole matter. The therapeutic usefulness of these last-mentioned experiences, experiences of introjection by the therapist, is, I believe, very great; they seem to me to constitute the essence of the therapist's empathic sensing of what is transpiring in the patient. And, as I indicated in a paper in 1955, this same process, carried one interpersonal link further, helps the supervisor to sense what is occurring at a deep level in the therapeutic relationship that is being described to him by the therapist in the supervisory session (19).

And, as regards the therapeutic relationship itself, although I have utilized here the frame of reference of the patient's *vulnerability* to the therapist's unconscious processes and, in keeping with this emphasis, have presented examples of disturbances in patients' behavior in this connection, one can see on the other side of the coin an invaluable communicational aspect to this. It is as if the patient were trying to tell the therapist, in all three of the varieties of introjective manifestations I have described, "See, this is the way you look to me," or, "See, this is what is going on between us, below the surface."

I believe that the constructive aspect of these introjective processes in the therapeutic relationship resides not only in this furtherance of *communication,* but resides also in—to present a formulation, now, at which informal discussions with John L. Cameron, a colleague on the Chestnut Lodge staff, have helped me to arrive—a process that is even more directly therapeutic. I refer here to the seeming circumstance that the therapist, at the deepest levels

of the therapeutic interaction, temporarily introjects the patient's pathogenic conflicts and deals with them at an intrapsychic, unconscious as well as conscious, level, bringing to bear upon them the capacities of his own relatively strong ego, and then, similarly by introjection, the patient benefits from this intrapsychic therapeutic work that has been accomplished in the therapist. Incidentally, I believe that the patient, on not infrequent occasions, gives the therapist the same kind of therapeutic help with the latter's intrapsychic conflicts. Concerning the benefits that the patient obtains by introjection from the therapist, the following comments by Hill (10) are of interest: "Schizophrenic patients . . . differ conspicuously from hysterical patients in their lack of immoderate admiration, affection, love, and so on, for their physician. . . .

"That the patient does not mention those qualities of his physician which he admires does not mean that he fails to note them. What he does with them is characteristically schizophrenic. *He takes them in as if they were mother's milk, thereby incorporating some of the goodness which comes to be his own and upon which his ego feeds and grows* [italics mine] . . . He is good, and the badness is left with the doctor. . . ."[8]

Wexler (21) and Hoedemaker (11) also have published valuable clinical examples of, and theoretical observations about, schizophrenic patients' recoveries as being facilitated by introjective responses to the therapist. Both these writers have overlooked, however, the *mutual,* two-directional, nature of this process, and have taken little note of the fact—in my experience—of the therapist's participation here upon unconscious, as well as conscious, levels.

My final observation is directed toward those therapists who do not yet have relatively thoroughgoing personal analysis, and lengthy clinical experience, behind them; to others, this comment will be superfluous. I would regard this paper as having been harmful, rather than helpful, if it accentuated a therapist's irrational feeling of responsibility for what transpires in the therapeutic session, and in the overall course of the patient's illness. The therapist has a responsibility, to be sure, and it is a large one; but it is shared with many other persons, including the patient himself, and it does not extend to the irrational extent of requiring that one be free from the influence of one's own unconscious. I have long ago become convinced that, quite on the contrary, psychotherapy with schizophrenic patients requires that the therapist become able to rely, more and more readily, upon his unconscious as being in the nature of a friend, a friend indispensable both to himself and to

his patients. Among such clinical incidents that I have described from my own experience, even those that at the moment caused me the greatest dismay proved subsequently to be of inestimable value in illuminating the nature of the transference as well as the countertransference.

NOTES

1. In this paper the terms *incorporation* and *unconscious identification* will be regarded as synonymous with the term *introjection*. If these three terms refer to different psychodynamic processes, I have failed, despite careful perusal of the literature concerning them, to discern any such differences.
2. Reference No. 10, p. 53.
3. Reference No. 10, p. 127.
4. Reference No. 10, p. 156.
5. Reference No. 10, p. 153.
6. Reference No. 7, p. 425.
7. A few days ago, for instance, I read the following item in the daily nurses' report concerning one of my female schizophrenic patients. This item was written by a middle-aged female attendant who has an excellent relationship with the patient: "Called me to rub her back. Says she has my knees. 'Why, Ruth?' 'Because my knees hurt.' 'How did you know my knees hurt, Ruth?' 'Last week you walked funny and this week you don't.' I told her that was because I was wearing my arch supports. 'I'm glad for you; but every time you get a new body they give me your old one, and you change bodies so often.' I told her it was the same old body but just bulged more in some places. She had a good laugh over that one and laid her head over against my arm. Says there are people in her legs and their heads are the hips."
8. Reference No. 10, pp. 205–206.

REFERENCES

1. Abraham, K. A short study of the development of the libido. In *Selected papers*. Institute of Psycho-Analysis and Hogarth Press, London, 1927.
2. Allen, C. Introjection in schizophrenia. Psychoanalyt. Rev., 22: 121–137, 1935.
3. Barchilon, J. On countertransference cures. Unpublished paper presented at the April, 1957 meeting of the Washington Psychoanalytic Society.
4. Bowen, L. M. Quoted in the transcript of the Combined Clinical Staffs of the National Institutes of Health, Clinical Center Auditorium, March 29, 1956; mimeographed by the Department of Health, Education, and Welfare; National Institutes of Health, Bethesda, Maryland.
5. Bychowski, G. A case of oral delusions of persecution. Internat. J. Psycho-Analysis, 11: 332–337, 1930.
6. Eissler, K. R. Limitations to the psycho-therapy of schizophrenia. Psychiatry, 6: 381–391, 1943.
7. Fenichel, O. *The Psychoanalytic Theory of Neurosis*, p. 428. W. W. Norton, New York, 1945.
8. Freud, S. The future prospects of psycho-analytic therapy. In *Collected Papers*, vol. 2. p. 289. Institute of Psycho-Analysis and Hogarth Press, London, 1953.

9. Greenson, R. R. The struggle against identification. J. Am. Psychoanalyt. A., 2: 200–217, 1954.
10. Hill, L. B. *Psychotherapeutic Intervention in Schizophrenia.* Univ. of Chicago Pr., Chicago, 1955.
11. Hoedemaker, E. D. The therapeutic process in the treatment of schizophrenia. J. Am. Psychoanalyt. A., 3: 89–109, 1955.
12. Johnson, A. M., and Szurek, S. A. The genesis of antisocial acting out in children, and adults. Psychoanalyt. Quart., 21: 323–343, 1952.
13. Limentani, D. Symbiotic identification in schizophrenia. Psychiatry, 19: 231–236, 1956.
14. Little, M. Counter-transference and the patient's response to it. Internat. J. Psycho-Analysis, 32: 32–40, 1951.
15. Nunberg, H. The course of the libidinal conflict in a case of schizophrenia. In *The Practice and Theory of Psychoanalysis.* Nervous and Mental Disease Monographs, No. 74, New York, 1948. This paper was first published as: Der Verlauf des Libidokonfliktes in einem Falle von Schizophrenie. Internat. Ztschr. Psychoanal., 7: 301–345, 1921.
16. Schroff, J. Acting out in a patient with a character neurosis. Unpublished paper submitted in 1957 to the Education Committee of the Washington Psychoanalytic Institute.
17. Searles, H. F. Data concerning certain manifestations of incorporation. Psychiatry, 14: 397–413, 1951.
18. Searles, H. F. Dependency process in the psychotherapy of schizophrenia. J. Am. Psychoanalyt. A., 3: 19–66, 1955.
19. Searles, H. F. The informational value of the supervisor's emotional experiences. Psychiatry, 18: 135–146, 1955.
20. Searles, H. F. The effort to drive the other person crazy—an element in the etiology and psychotherapy of schizophrenia. In *Collected Papers on Schizophrenia and Related Subjects,* pp. 254–283. International Universities Pr., New York, 1965.
21. Wexler, M. The structural problem in schizophrenia: the role of the internal object. In *Psychotherapy with Schizophrenics,* Brody, E. B. and Redlich, F. C., eds., pp. 179–201. International Universities Pr., New York, 1952.