



The Patient and the Psychotherapist: Comments on the "Uniqueness" of Their Relationship

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Love is the active concern for the life
and the growth of that which we love.
(Erich Fromm, *The Art of Loving*, 1956)

Introduction

My concern here is with certain aspects of the psychotherapeutic relationship that may contribute to what is frequently spoken of as its unique quality. The intensity and durability of the attachment that is developed suggest that it contains elements of affection, friendship, and love which make it "more than" a technical, clinical exercise in the treatment of psychiatric disorder. Speaking to this point William Snyder says: "It is evident that therapy is often a major human experience, one of life's high spots, especially for the clients, but also many times for the therapists."¹ I have myself experienced the therapeutic relationship as being marked by properties uncommon—if not lacking—in other interpersonal contacts. It is difficult to specify what "works" in therapy—what is therapeutic—and [016] effectiveness is probably the reflection of a combination of factors, rather than the result

simply of gaining insight, and so on. However, our interest at the moment is not so much in what may bring about desired change in a troubled patient, but in some of the elements possibly associated with the participants' sensing of the situation as being extraordinary and curious.

The word love is avoided here, not because I doubt the existence or usefulness of the sentiment, but because the term refers to a wide range of subjects extending beyond my professional competence and my personal knowledge. Some years past I said to a patient that, in my opinion, love was not in itself a curative agent. The reply was—with emphasis: "You are very likely wrong." Perhaps—but I should not speak casually of what

I am unable to define or identify with a fair degree of clarity. Thus no attempt is being made to attribute the uniqueness of the therapeutic encounter to a concept—love—which too often is an elusive and ephemeral phenomenon, for the most part private and poorly comprehended. The following remarks by Joseph Conrad seem to me to have some relevance at this juncture:

Everybody shows a respectful deference to certain sounds that he and his fellows can

¹ William Snyder, *The Psychotherapeutic Relationship* (New York: Macmillan Co., 1961), p. 2.



make. But about feelings people really know nothing. We talk with indignation or enthusiasm; we talk about oppression, cruelty, crime, devotion, self-sacrifice, virtue, and we know nothing real beyond the words. Nobody knows what suffering or sacrifice mean —except, perhaps, the victims of the mysterious purpose of these illusions.²

The ideas presented in this report—in no way original—may be applicable in some degree to psychotherapeutic interventions in general, but it may be useful to avoid as far as possible the extension of implications in ways that cannot be firmly supported by theory based on clinical observation. I shall limit my remarks to personal reports of my own work with certain schizophrenic patients, making no claim to true scientific objectivity or the immediate relevance of these views to other persons in differing circumstances.

The Posing of the Question

In considering my own current and past experiences as the therapist of schizophrenic people, I am impressed by the seeming (if not actual) clarity [O17] with which I recall them and the details of our involvements with each other. Although these associations were often stormy, and in a conventional sense unpleasant, they usually persisted and ties developed that were maintained despite the absence of much personal contact after the termination of the work. There was more to these attachments than the therapist's wish to fulfill a professional obligation or the patient's uncertain hope for change. The contacts had been marked by a wide range of shared feeling—tenderness as well as anger, dislike, and the inchoate eruptions in states of panic—and the relationships (in reality and memory) had come to be significant and valued parts of my life. How did this come about? The question has been raised repeatedly—by patients

and by myself. There follow some examples.

John was a man in his early twenties when we first met. He had left college in his first year because of an inability to concentrate on his studies, a growing sense of confusion, a conviction that he was worthless, and a persistent fear that he was being followed and spied upon. Awakening from a poorly remembered nightmare that seemed to imply certain implications of incest with a woman vaguely resembling his mother, he leaped from a second-story window without serious injury to himself and thereupon became withdrawn and mute. Although I met with him daily in his hospital room, he was silent for many weeks and seemingly paid no heed to my presence. When he no longer lay quiet on his bed or the floor, he often ordered me out of his presence and attacked me physically if I did not leave. On later occasions he spoke of our relationship: "Somehow we have become important to each other. You often seem very dangerous to me, and I sometimes think that I shall simply do away with you. I don't understand this; why can't I rid myself of you?"

Mary was twenty when I became her therapist in a hospital. She had grown depressed and socially isolated in her third college year, and her thinking became so disorganized that she left school. She went from one psychotherapist to another, finding no one suitable to her, and after a year of moving about made a serious suicidal attempt. During much of the several years that we worked together she directed a hostile vindictive attack at me. She sought out my personal idiosyncrasies and defects with remarkable perceptiveness and precision and often spoke so cruelly and yet realistically that her observations could not be dealt with as "psychotic." At other times she was frightened, hallucinated, self-mutilative, and required almost constant physical care. Frequently she dismissed me, insisting that I [O18] did nothing but harm to her, and accusing me of remaining as her therapist only out of my own evil and destructive intent toward her. After a few months she said: "You're unique. There is no one like you. You're not my father or one of my brothers. You're not my mother. You don't seem like a doctor. You are not anything I can put my fin-

² Joseph Conrad, "An Outpost of Progress," in *Typhoon and Other Tales* (New York: Signet Classic, published by New American Library, 1962), p. 197.



ger on. I don't know who you are, and I don't know what to do with you. What is this I'm getting into with you?"

Jane also had been in treatment for short periods with several therapists before we met when she was twenty-four. College had been a near disaster because of her lack of interest in her work despite obvious talent in painting and her hostility so apparent in situations marked by authority or increasing intimacy. However, she did graduate and soon married, an unhappy move made apparently in an effort to shore up a rapidly declining self-esteem. Her marital and social adjustments were marginal, she became withdrawn and moody, and then entered a state of panic in which she cut herself, attacked her surroundings, and required restraint. The work with me was stormy and was continued for several years, during which Jane displayed a variety of behaviors—being recurrently assaultive, withdrawn, mute, mutilative, dejected, and on occasion apparently free of anxiety and any discernible evidence of psychosis. With time she improved, and our work drew to a close. My wife, a psychiatric nurse of long experience and great skill, had worked with me and Jane, and these two women liked each other.

Some time after the discontinuance of treatment, Jane visited us at our home, and we had afternoon tea on the lawn in the later hours of a lovely summer day in Maryland. In the course of the little meal, Jane and I entered upon a discussion—of what I do not remember. Gwen, my wife, listened with interest and at some juncture said:

"I am fascinated by the way you talk with each other; there's something unusual about it. It isn't quite the way we talk (turning to me). It's as if you two knew something about each other that I don't know—you've had some kind of experience that's done something to you, and it's interesting to observe. In some ways I envy you."

Jane looked surprised: "What do you notice? You're married to this man. You are close to him; you have lived with him a long time, and you have children by him. As far as I know you get along well together—I expect you love each other. I've just been a patient, and you are a wife and mother. You two live together and I

suppose will continue to do so, while I'm leaving. What is there to envy?" [O19]

Gwen's reply was simple: "Perhaps envy isn't the right word for what I feel because I don't feel unhappy. I have just noticed something that's different. You two don't talk like patient and doctor—and not quite like I talk with him (nodding toward me). Maybe it's a reflection of the experiences that you've had together. Anyhow, there is a difference—something unique."

The therapeutic relationship is at times experienced as being "like" something else, the therapist then dealt with apparently as father, mother, sibling, lover, friend, enemy, nightmare figure, and so on. Other terms may be used to describe its emotional qualities; among these (often borrowed from linear and thermal measurements) are warm, cool, cold, close, distant, or whatever. No terms—or combination of them—can adequately depict the nature of human involvement, and I am not attempting to picture here what can better be done by artist and poet. Our interest now is in what some patients, therapists, and other observers say about certain therapeutic attachments, remarking on such characteristics as durability, intensity, and a quality of "uniqueness" difficult to define.

The Person With Whom We Are Concerned

In the service of avoiding excessive generalization, some comments should be made regarding the kind of person with whom the psychotherapist develops these attachments. Obviously, the therapist himself must be considered as a major component in these transactions—influencing and being influenced by whatever goes on in them. More of the therapist later, it being recognized that other and more detached observers would likely give different—but not necessarily more significant—accounts of these events.

The focus of our attention is a person who has been diagnosed as schizophrenic and saddled with an unwelcome role—patient—which he may deny, resist, or accept with feelings of despair and humiliation. Despite the teachings of the past thirty years or more, the long-standing dread of dementia praecox and schizophrenia persists, the diagnosis continuing to imply hope-



lessness, irreversible withdrawal if not deterioration, and a "living death." The frequent occurrence of the disorder, the disagreements as to its origins, the multiple and changing modes of treatment, the uncertainty as to outcome, and the expense of attempted relief in terms of effort, money, and time would seem to justify serious concern—but not [O20] dread, a word implying something evil, mysterious, and beyond human understanding.

As the word is used here, schizophrenia does not refer to a specific disease entity in the classical medical sense. Psychiatric staff conferences today frequently remind me of those in which I participated years ago, the members attempting—often without clear-cut agreement—to describe and assess the behavior of another human being and to apply a label to him. This is no simple task, as nothing that we say seems to fit, the person and his ways of living being too elusive to be ensnared in the net of our nomenclature. We may refer to him as borderline, schizoid, possessing a schizoid character disorder with obsessional traits, schizophrenic with depressive and hysterical features, and so on. We continue to be unclear regarding the identity of this person and his ailment.

In 1928 Sullivan had the following to say about diagnosis:

Continued experience with mentally disordered persons weakens the writer's hope of finding clear nosological entities. The more one learns of what is going on in his patient, the less faith he can retain in the alleged types of anomalous and perverted adjustive reactions. The field of mental disorder seems to be a continual gradation, in which little of discrete types is found.³

Four decades later, in 1969, Burnham, Gladstone, and Gibson directed their attention to the same topic:

It may be well ... to state our belief that as yet we possess no single, comprehensive, and adequate theory of schizophrenia. This is partly because schizophrenia is not a dis-

crete nosological entity. ... The phenomena which are encompassed by the label schizophrenia are so diverse and far reaching that construction of a unitary explanation is exceedingly difficult. ... The point we wish to emphasize is that any sense of orderly classification associated with using the label schizophrenia may be partly spurious. Accordingly, when we speak of the "schizophrenic person" we should be aware that our capacity to generalize within a clearly established uniform class of persons is limited.⁴

However much uncertainty there may seem to be, there is evidence to support the following views. Obscure as it often is, schizophrenic behavior [O21] is simply human, is not "unpsychological," is to a large extent learned and thus reflective of experience (current, past, and anticipated), and expresses motivation in the sense of a goal being sought. Our attitudes to human relatedness have their origins in infancy and are further molded by social contacts of later years leading to the more permanent consolidations of identity in adolescence. The background of schizophrenic maladjustment can be sought for in the institutions of the past—family, culture, and society; the reasons for its continuance must be looked for in the demands of the present and the expectations of what is to come.

Because of the variety of behaviors encompassed by the word schizophrenia, it is not satisfactory to speak of the unique quality of a therapeutic relationship with a schizophrenic patient. A greater degree of specificity is required—and will be sought.

The people with whom we are concerned in this discussion had, in general, certain characteristics. Their ages ranged from seventeen to thirty-five years, they had passed the puberty change without being identified as a "psychiatric case" (although the early years may have been stormy at times), and they had achieved some recognized social success in adolescence. All had engaged in heterosexual experience with some

³ H. S. Sullivan, "Tentative Criteria of Malignancy in Schizophrenia," *American Journal of Psychiatry*, 7 (1928), 760.

⁴ D. L. Burnham, A. I. Gladstone, and R. W. Gibson, *Schizophrenia and the Need-Fear Dilemma* (New York: International Universities Press, 1969), p. 15.



gratification, although the seeking of bodily contact, physical closeness, and a form of human relationship were more important than the satisfaction of lustful interests. They were of superior intelligence, had completed the twelfth grade or more, and possessed high degrees of verbal skills, usually being able to present themselves in interesting and often picturesque ways. In each instance the appearance of publicly recognized disorder followed upon events experienced as stressful by the individual concerned, although without knowledge of his past life the stress might be looked upon as minimal or not unusual and thus could be overlooked at the time of its occurrence. In the main such stress was related to fear of object loss, separation, and the accompanying threat to self-esteem and personal identity. The time of onset was difficult to specify; as one came to know the person better, it was seen that premonitions of difficulty were present in earlier years (childhood and often infancy), and the disorder seemed to reflect the accumulation of maturational insults and learning defects from the first year of life.

The onset of "clinical signs" in this group is usually acute—an often dramatic separation from the hitherto seemingly normal course of living. Although such a person seems to need and want a close human relationship—and offers promise of giving a great deal to it—he tends to [O22] be suspicious and fearful, with the result that contact with him is usually marked by a tantalizing and often seductive quality of approach and withdrawal.

The form of the relationship in respect to its intensity and the way in which it is experienced will depend in part on the sex of patient and therapist, the acceptance of closeness by both in regards to the sex of a partner, and the cultural traditions in this regard—such as closeness between males being looked upon as dangerously "homosexual." However, the features of relatedness to be noted later may be common in any couple designed to be therapeutic.

The Opportunity and Hazard of Adolescence

The people in this group had encountered great difficulties—and had, as a result, exposed per-

sonal handicaps—in attempting to deal with the tasks of adolescence. Among the tasks found to be so difficult were these: 1) the development of intimacy with peers of both sexes, permitting self-revelation, and the modification of persistent autistic concepts—most of which should have been corrected in earlier eras of growth (particularly in the juvenile era); 2) the combining of the needs for intimacy, for lustful satisfaction, and for the maintenance of security and self-esteem in such a way that they can all be met to a tolerable extent with another person—usually *ja'i* the opposite sex; 3) the patterning of sexual behavior in a dependable and gratifying fashion consistent with personal ideals and an acceptable concept of the self; 4) a sense of personal identity that is enduring, pleasing, and to some extent publicly acceptable; 5) a system of values, identifiable, persistent yet modifiable, and harmonious with what one conceives himself to be; 6) separation from the family of origin—emotionally, and frequently physically to some extent; 7) a career choice that fits with—and hopefully may expand—the self-concept; and 8) a social role consistent with personal identity and permissive of further personality growth. The inability to deal with these requirements and their like reveals a social ineptitude reflective of learning deficiencies that have accumulated throughout the years. Attempts to conceal such inadequacies may result in behavior so deviant as to invite public attention and response, leading to the enforced adoption by the youth of the role of patient—if not criminal, or other.

The schizophrenic processes as here dealt with are considered to be largely a resultant of developmental experiences—i.e., personality [O23] characteristics formed through failures in the acquisition of interpersonal and social skills, and defects in the matching of biological potential with interpersonal, social, and cultural influences at appropriate times on a sequential scale. We cannot speak of possible genetic differences in this group in contrast to others, but it is noteworthy that these (if present) plus the varied traumata of earlier years have not been sufficient to interfere to such an extent with growth that adjustments (or seemingly adequate compromises) are made to enable living to go on



uninterrupted by psychiatric interferences into early or mid adolescence. (These last terms are used here in a developmental rather than a chronological sense, the number of those reaching the latter grouping far exceeding those who attain the former.) It should be noted that adolescence—particularly in its earlier stages—is (like infancy) potentially an era in which there is the opportunity for great change of personality and correction of previously acquired warp or deficit.⁵

Implications Regarding Early Development Derived from the Above

The person described here has great difficulty in relating to people—to a world of "objects"—without the experience of severe anxiety and the resulting development of behavioral complications ("defenses" or "security operations") designed to maintain a sense of personal security and to permit a semblance of intimacy—or at least of human contact. In view of 1) the observation that the troublesome behavior labeled schizophrenic is demonstrated largely in an interpersonal-social field, and 2) that the intrapsychic structure of the personality is a reflection of the transactions involving the developing organism with the "external" environment, attention is drawn inevitably to the earlier life experiences of the individual within the social fields of the mother-child relationship, the family, the immediate society, and the larger culture. In brief, disorder does not come from "out of the blue" but arises from the present dealt with in terms of the past—the biological given and the social influence.

The human infant, lacking a wide range of dependable instinctual [O24] responses, must deal with problems of existence in his early months through dependency on a mothering person. Again, Sullivan:

⁵ See H. S. Sullivan on adolescence, *The Interpersonal Theory of Psychiatry* (New York: W. W. Norton & Co., 1953), chaps. 17 and 18; M. S. Mahler, "On Human Symbiosis and the Vicissitudes of Individuation," vol. 1, *Infantile Psychosis* (New York: International Universities Press, 1968), p. 49.

The human animal is utterly dependent at birth and, diminishingly but still greatly, dependent on the tender cooperation of the human environment for five or six years after birth. ... The abilities that characterize him are matured serially over a term of no less than ten to twenty years. ... It is likewise clear that the inborn potentialities which thus mature over a term of years are remarkably labile subject to relatively durable change by experience, and antithetic to the comparatively stable patterns to which the biological concept of *instinct* applies.⁶

And Mahler:

It seems that psychosis is the sad prerogative of the human species. ... Animals are born with well-developed instincts, which guarantee their independent individual survival long after birth. [A statement too general to be accepted in terms of modern studies in ethology— O. A. W.] In the human young ... these animal instincts ... have atrophied and become unreliable. ... The psychobiological rapport between the nursing mother and the baby complements the infant's undifferentiated ego. This normal empathy on the part of the mother is the human substitute for those instincts on which the animal is able to rely for survival.⁷

Each era of personality development provides an opportunity—in theory, at least—for the matching of action with growth potential resulting in further maturation, and for the correction of earlier developmental deficiencies. The later exposed abnormalities of social facilitations are indications of failures in that which has gone before—the relationship of mother and child, of child with family, of family with society, and so on. The above, however, should not be taken as a recommendation for a continuum of "adjustment" to the compelling mores of any particular culture or society. From this point of view,

⁶ Sullivan, *The Interpersonal Theory of Psychiatry*, *op. cit.*, pp. 20-21.

⁷ Mahler, *op. cit.*, pp. 33-34.



schizophrenia is not to be explained away as a revolt against the establishment, as a seeking for a "new life," as a superior way of living, or as a philosophy in itself. Schizophrenia—as the word is used here—describes an attempt (overly complicated or simplified) [O25] to maintain a relationship with other human beings in the face of severe anxiety. Schizophrenic behavior is in itself not a philosophy but an expensive and complicated attempt to survive as an organism in a troubled interpersonal milieu which is both frightening and necessary.

The early-life interpersonal—or interhuman (a term better suited to infancy before what we call "personality" has advanced in development)—experience of the human being later to become schizophrenic has (by inference) been marked by extreme anxiety prior to the development of speech skills and the clear-cut separation of object and self. The responses of the infant to anxiety are limited; they include somnolence, withdrawal, dissociation, the formation of distorted images of body and self, the perpetuation of autistic processes, and distortions of perceptions. Such malformations are subject to modification—favorable or otherwise—by later events, but the schizophrenic person has benefited but little from such correction.

The human infant is unable to escape physically from a mothering or other social situation upon which his further development depends; for years his inability to care for himself binds him to an environment which may be noxious, as well as beneficial, and which is the major force in forming his personality. In order to keep on living in an atmosphere which may be in many ways (often subtle and dimly perceived) destructive, it may be necessary to develop illusions and misperceptions about the events in which one is involved. Aspects of experience which do not fit in with such illusions and an associated acceptable concept of the self may be "dissociated"—that is, kept out of awareness by the complicated device of carefully noticing what not to notice, and avoiding any elaboration of the implications of those events which might seem to threaten an already flimsy self-esteem.

Under the pressure of various circumstances—such as the demands of adolescence,

separation from long-held attachments of great personal importance, acute disruptions of organic integrity (as in disease or injury), prolonged and severe fatigue and fear, and drug intoxication—the "defensive" patterns of behavior (including denial, obsessionalism, hysterical incapacitations, and so on) may prove to be inadequate, with the result that anxiety increases, dissociation "fails," and there enter into awareness symbolic fragments of previous experience hitherto not included in the concept of the person as known to himself. These bits of thought and related emotions have no clearly perceived referents in the past or present; they often embody poorly understood but seemingly fateful cultural prescriptions [O26] regarding good and evil, and are so foreign and frightening that the person involved in all of this finds himself in a nightmare that makes no sense but must be resolved rapidly and hopefully understood or else abandoned and somehow forgotten. This is the state of panic—marked by a sense of personality disorganization, of the sudden unreliability of all that one has come to depend upon, and the loss of relationship with those people, things, and ideas that have come to matter in one's life. This is the essential schizophrenic experience, urgently requiring solution, and leaving the victim with a persistent dread of its recurrence. Mahler speaks of the above as follows:

I should like to point to the lasting validity of what Freud regarded as the essential criterion for the psychotic break with reality—namely, the slipping away of the libidinal human object world. We can rarely observe, but are often able to reconstruct, the prepsychotic struggle, the desperate efforts to cling, to hold on to the human object world. "Psychotic object relationships," whether with human beings or otherwise, and "psychotic defenses" are therefore no more than restitutive attempts of a rudimentary or fragmented ego which serve the purpose of survival. No organism can live in a vacuum, and no human being can live in an altogether objectless state.⁸

⁸ *Ibid.*, p. 64.



The Patient

When the person under consideration becomes "disturbed"—that is, so incapable of dealing with his predicament in an acceptably conventional manner that his associates no longer want a part of his deviant behavior—he may become a patient, a role for which he usually has no enthusiasm. From his early years has been derived a lack of basic trust and little confidence in himself and others. His low self-esteem leads him to be vulnerable to the opinions of anyone, and his fragile sense of identity is easily shaken when he is made anxious. The tie to human relationships has been formed and is not readily renounced, but the related anxiety leads him to suspect and fear any person whose attention, affection, and regard he needs; he acts as if this person (or "object") might destroy him, be destroyed by him or, despite his (or its) evidences of goodness, finally be revealed as evil—in any case, he will be deserted and alone. [027]

In the service of diminishing and controlling anxiety in interpersonal contacts, major systems of ideas and emotions must be kept from awareness through the use of elaborate maneuvers, with the result that any relationship approaching intimacy becomes complicated and tenuous, characterized by suspicion, movements of approach and withdrawal, testing, and the constant threat of separation through flight, psychosis, or suicide.

Although affection and closeness are desired, they bring with them the threat of revealing dissociated experience with the accompanying disturbance of the precarious concept of self and the exposure of the person once again to the horrors of panic. There are "choices" available to the patient—and no one is easily attained or simply desirable; all are unpleasant and each is costly. If the patient withdraws, he foregoes human contact except in a rudimentary and stereotyped form (as in the care given to a chronic "regressed" patient) and in whatever he retains of fantasy. Killing the object is not an adequate solution, as there is the threat of replacement; and suicide, if intended to bring about some magical "rebirth" or change in self and others, is not likely to be successful in any

sense. Attempts to distort the world into a more tolerable form through denial, delusion, and hallucination perpetuate estrangement and psychosis and restrict to a large extent further profitable personality change. Psychotherapy that may prove to be useful cannot be in itself persistently pleasurable and is sure to be perceived as recurrently threatening and destructive—as through this relationship the hidden, frightening past, long held to some extent at bay, will come into the open and be made part of the self.

Guntrip's remarks are relevant here:

The schizoid feels faced with utter loss and the destruction of both ego and object, whether in a relationship or out of it. In a relationship, identification involves loss of the ego, and incorporation involves a hungry devouring and losing of the object. In breaking away to independence, the object is destroyed as you fight a way out to freedom, or lost by separation, and the ego is destroyed or emptied by the loss of the object with whom it is identified. The only real solution is the dissolving of identification and the maturing of the personality, the differentiation of ego and object, and the growth of a capacity for cooperative independence and mutuality; that is, psychic rebirth and development of a real ego.⁹ [028]

The Therapist

In a discussion of the attachment holding our attention here, the therapist as a person must be considered. We refer to someone who has been trained as a therapist, has some familiarity with personality and psychoanalytic theory, and has himself undergone personal analysis. However, personal therapy and knowledge of theory do not—and are not intended to—remove the human qualities of a therapist and make him into some sort of a machine. He continues to be a

⁹ H. Guntrip, *Schizoid Phenomena, Object Relations, and the Self* (New York: International Universities Press, 1969), p. 48.



human being, and will probably discover repeatedly that his objectivity and his therapeutic role (narrowly defined) are encroached upon by his personal needs. It is required of the therapist that he have no major motivational systems outside of his awareness. Should these exist, they will be called into play and will influence his behavior as the integration of the therapeutic relationship develops. Unless he walls himself off through a denial of his own existence, the therapist will be aware of a variety of responses—and is required to deal with these in ways judged to be beneficial to the growing freedom of his patient.

Some of the therapist responses that complicate work with patients (schizophrenic and often otherwise) and that are common in this form of relationship are briefly reviewed as follows:

1. The schizophrenic patient may be looked upon as a "challenge" and his improvement as a way to demonstrate (supposedly) some particular combination of talents in the therapist.
2. The patient may be used as a piece—as in a game of chess—whereby the therapist enters a competition with colleagues to "prove" the alleged superiority of a particular "method" or "school," or seeks to demonstrate that those who taught him were "right"—or perhaps "wrong."
3. The patient may become—unfortunately—an object of fascination revealing (or being led to reveal) behavior actually, or supposedly, confirmatory of some prized theory of personality; such patients, finding an anxiety-reducing and self-perpetuating fitting of personal needs with needs of a therapist, may provide a seemingly unending source of "material" without themselves undergoing significant or beneficial change. They are mines of information, finding strange refuge in the sought-for particularization of their experience; being a patient becomes a career, matching that of "being a therapist."
4. Therapists have, in varying degrees, needs to exercise power—to [029] control and dominate. Some patients have reciprocal needs—to be controlled and dominated. The matching of such needs may lead to a reduction of discomfort in both participants, in which case each will seek to perpetuate a relationship that is comforting but therapeutically unprofitable in that change is prevented.
5. In his seeking for closeness and security with another person, the schizophrenic patient may display a form of seductiveness and seeming affection that imitate (if there is excessive need for this on the part of the partner) a form of love. The acceptance of such attachment as simple devotion will have—in one sense a useful, and in another a destructive—function. That is, the required therapeutic investigation will be hampered if not destroyed.
6. Over long periods of time with a withdrawn, unresponsive, and perhaps mute patient, there may develop fantastic concepts of patient, therapist's self, and the relationship. In response to personal needs of both participants, the patient (and therapist) may be cast into more or less private roles—such as child, parent, sibling, mother, and so on—without there being understanding or much valid confirmation for any of these.
7. With the passage of time, an analyst may find that his world is—as he sees it—peopled largely with patients, and he may discover (or deny) that he is in some sense isolated and alone—and perhaps lonely. He has become a therapist, teacher, adviser, counselor, and a senior member of an establishment that he may have denied and resisted while it more or less subtly encompassed him. He discovers that there is no longer a place to go or a person to whom he can turn for a revealing of his discontents and personal "weaknesses." Then he may turn—without knowledge, or if with that, then with guilt—to his patient for relief. The patient—who has often known something of what it is to be confidant and parent to a parent—may meet the dependency requirements of his therapist, and in so doing experience a decline of anxiety but fail to separate from his past, having found it in his current present.
8. Therapists properly take pleasure in the betterment of their patients, but the need to



heal, to change, and to reform is a handicap in treatment, as it reflects a form of self-involvement—narcissism—that leads to treating the patient impersonally and as an object.

9. The necessity to participate vicariously in the lives of patients—in the reports of their escapades—may lead to a perpetuation of such accounts without benefit. For example, the therapist may respond to an [O30] invitation to play the part of being someone better than an allegedly hurtful parent, or to release (in fantasy at least) his own sadistic feelings now mirrored in his patient's accounts of relatives' cruel behavior.
10. There are motivations other than the above, operating to continue a therapist in his work but jeopardizing the possibility of its useful outcome. At the very least the therapist must be knowledgeable about these aspects of himself; their persistence or their great strength may disqualify him for his task. However, the therapist is not required to be somehow beyond the frailties and the hazards of his human condition. The existence of his defects, once recognized, can be put to good use as information regarding the course of treatment—signposts of the developing relationship not be to disregarded lightly.

The above is no more than suggestion. We properly can concern ourselves with the "kind of person" who is a therapist and the motives that lead him to form an abiding interest in patients such as these described here. Why does one turn his attention to a line of work that in many ways offers little reward—in terms of money, prestige, professional advancement, or (in the conventional sense) pleasure? The task is in itself not ennobling. Does the therapist simply seek further knowledge of himself through observational involvement with his patient? Does he hope to allay some long-endured guilt because of a suspected—or known—crime against his conception of humanity? Does he repeatedly attempt to correct some failure of his own to be an understanding and loving person by discovering and demonstrating these qualities in the consulting room?

All of the above justifies further consideration—but not here. It is evident, that for better or worse, the therapist as I know him is not an "influencing machine" or a "reflecting mirror" in any simple sense of these descriptions. He is both an observer and a participant—required to know what he is about, to accept with humility the humanity and limitations of his position, to aid another without damage, and to recognize that for whatever he does (or does not do) there will be consequences—often not easily remedied.

Factors Possibly Related to the Quality of "Uniqueness"

There are several factors that may contribute to the special quality of the therapeutic relationship as outlined above. Certain of these influences are operative in any form of psychotherapy, but our concern here is [O31] arbitrarily limited to work with the schizophrenic patient. Although the course and the results of treatment will depend to a large extent on the personality characteristics of those involved—irrespective of their designation as therapist or schizophrenic patient—attention at this point is given to the factors themselves without regard to their interplay and to the significance of other possible influences.

The Formation of Relational Bonds

A basic requirement of an organism—such as man and other mammals—is to develop early in life an attachment (commonly to an adult of its own species) that will favor its survival.¹⁰ The human infant will not survive if its behavior is not met by appropriate, tension-relieving responses from the mothering one. If the responses are suitable and well-timed, tensions are reduced and patterns of "needs" are developed through the reciprocal transactions which are the beginnings of interpersonal relatedness. It

¹⁰ No attempt is made in this paper to review the numerous studies that have been made of the early attachment of the young to a nurturing person.



was suggested earlier that variations in this process of attachment range from disasters marked by the infant's withdrawing from human contact into death (so-called marasmus) to what we sometimes carelessly name "adaptability" and "normalcy." Intermediate reflections of difficulties in the early formation of relational bonds may be found in infantile autism, childhood psychosis, and the schizophrenic phenomena of adolescence described here. (Note that the term adolescence refers more to a developmental stage than to chronological age. Thus a person in his twenties—or older—may continue to struggle with problems supposedly dealt with in the teens.)

The formation of social bonds takes place most readily at certain times of development called "critical periods." This term is defined by Scott and Fuller as "a special time in life when a small amount of experience will produce a great effect on later behavior."¹¹ In the human being (quoting Scott), "The present evidence indicates that while the period of six weeks to six months is a critical one for the formation and determination of social relationships, the later ages are also critical with regard to psychological damage resulting from breaking off these relationships."¹² [032]

Although in man the time of primary socialization is from the first six weeks to six months, critical periods are not so clearly delineated or fixed as in other animals, with the result that modifications in the form of relationships can, theoretically, take place at any age. As noted earlier, adolescence is an era of potential rapid learning and alteration of behavior. The following comment by Scott is relevant to this last:

... an individual at the proper period in life will become attached to anything in the surrounding environment, both living and

nonliving. ... In animals like dogs and people, it is likely that the capacity to form these attachments is never actually lost in adult life but simply takes place more slowly, usually because of various interfering patterns of behavior.¹³

In a review of attachment behavior, Cairns notes that research so far "indicates that social attachments can occur in the absence of assorted conditions that have been assumed to be primary."¹⁴ That is, attachment can form despite the absence of the following: lactation (as in the mother), immaturity of the subject (patient), physical contact between subject and object, and non-punitiveness of the object (mother, for example). In brief, social bonds develop in response to the proximity of one person to another and are not dependent on feeding, touching, age, or even kindness in the ordinary sense, but are facilitated by accompanying emotional arousal. Of particular interest is the observation that unpleasant, noxious components of the situation—elements usually associated with punishment—strengthened the tie between the participants.¹⁵

Although attachment between adults may be considered to be desirable, it is usually complicated by a variety of ideas regarding its nature and its propriety in terms of the culture. Is the attachment the result of, or evidence of, love, sexual interests, unwanted dependency, regression, or whatever? The schizophrenic patient (and others) may resist contact with the therapist, fearing that he will be "swallowed up," that once dependent he can never be "free," and that to need a relationship is evidence of "weakness" and infantilism.

The following by Bowlby is useful in this regard: [033]

That attachment behavior in adult life is a straightforward continuation of attachment behavior in childhood is shown by the cir-

¹¹ J. P. Scott and J. L. Fuller, *Genetics and the Social Behavior of the Dog* (Chicago and London: University of Chicago Press, 1965), p. 117.

¹² J. P. Scott, "The Process of Primary Socialization in Canine and Human Infants," *Monographs of the Society for Research in Child Development*, serial no. 85, vol. 28, no. 1 (Yellow Springs, Ohio: Antioch Press, 1963), p. 34.

¹³ Scott, *ibid.*, p. 38.

¹⁴ R. B. Cairns, "Attachment Behavior of Mammals," *Psychological Review*, 73:5 (1966), 410.

¹⁵ *Ibid.*, p. 414; see also J. P. Scott, "Critical Periods in Behavioral Development," *Science*, 138:3544 (November 30, 1962), 949-958.



cumstances that lead an adult's attachment behavior to become more readily elicited. In sickness and calamity, adults often become demanding of others; in conditions of sudden danger or disaster, a person will almost certainly seek proximity to another known and trusted person. In such circumstances an increase of attachment behavior is recognized by all as natural. It is therefore extremely misleading for the epithet "regressive" to be applied to every manifestation of attachment behavior in adult life, as is so often done in psychoanalytic writing where the term carries the connotation pathological or, at least, undesirable. To dub attachment behavior in adult life regressive is indeed to overlook the vital role that it plays in the life of man from the cradle to the grave.¹⁶

The basic ingredient of a relationship designed to be therapeutic is the formation of an attachment felt by the participants to be of some moment in their respective lives. Reference here is not made to relationships that develop with rapidity, are of short duration, and yet seem to lead on occasion to enduring change of personality in one or other of those involved. The relationships under discussion were slow to develop, were often threatened by premature dissolution, were repeatedly thought to be unprofitable and unpromising, and endured for two years or more, leaving a lasting impression on both patient and therapist. The elements of these relationships were the following—which is, perhaps, a gross oversimplification of a complex affair.

1. There were repeated meetings of the patient and therapist. These meetings lasted for an hour (sometimes more, if the patient was disturbed near the end of a session) and were held five to six times weekly. During a year there were about two hundred sessions. Although therapy was usually conducted in the therapist's office, there were times when that location was not suitable because of the patient's anxiety, and he

might then be seen in his room or on the hospital grounds.

2. In the great majority of these encounters there was a considerable amount of emotional arousal. The patient's anxiety, fear, hostility, despair, negativism, and even muteness stirred up feeling in the therapist. The sessions were usually marked by one's recognizing that he was [O34] engaged in a contest. The patient's need for involvement and his fear of it introduced an approach and withdrawal quality to the encounters that could not be dealt with impassively. The patient often put little trust in the therapist, and there was an almost constant threat to the maintenance of the relationship, which could be destroyed by withdrawal, death, or "outside" events, such as interference of family members. Thus there was often an exciting and almost adventure-some aspect to the work; it seemed to be carried on in an atmosphere of high risk.
3. The developing relationship was not formed in a neutral or friendly setting. The people spoken of here did not voluntarily seek help and expected little good to come from treatment or a human relationship. They were in a sense forced to be in the hospital, not necessarily through legal commitment but by the pressure of relatives and some recognition of their own social failure. As a result the patient frequently complained of being a captive, and the therapist was accused of being—and felt himself to be—unsympathetic, inhuman, and cruel. Therapy was carried on largely in the midst of anxiety and conflict despite the later occurrence with increasing frequency of periods of acknowledged trust and closeness.

The attachment of patient and therapist to each other developed even though the desired results of recognized improvement were not attained. Major ingredients of the tie were the meetings in which proximity was achieved, the stirring up of emotion, and the quality of tension and conflict usually experienced as unpleasant and undesirable.

I find it most satisfactory to meet with a patient five or six times each week and be in each

¹⁶ J. Bowlby, *Attachment and Loss*, vol. 1, *Attachment* (New York: Basic Books, 1969).



session for at least an hour. However, this is a personal preference, and the formation of relational bonds is not necessarily related to this frequency or duration. Of particular importance, perhaps, is the fact that patient and therapist are caught up in a situation from which neither one can easily escape. The patient may protest that he is a prisoner, and the therapist often feels that he is one also, being bound not only by professional interest and obligation but by the subtly growing relationship, which in a strange way becomes for a time a prison as well as a route to freedom.

There is in this confined struggle something akin to cruelty, which may be a factor in intensifying the attachment. There is also in all of this a symbolic reduplication of earlier life events. The infant is bound to the [035] mothering person by his need for nurturing and by his helplessness. If that situation is marked by anxiety, he cannot escape physically but only by emotional withdrawal (as in somnolence) and later by the manipulation of symbols and perception. In the later therapeutic relationship being considered here, escape is not easy, anxiety levels are often high, and efforts are made to prevent defensive withdrawal, intensifying the sense of frustration and conflict. Both participants usually feel that they have been in a fight, enjoyable at times but unforgettable. (Perhaps this sense of great closeness despite the struggle is not completely different from the emotions experienced by two boxers who embrace each other with appreciation and even tenderness when each has survived a bout entered willingly but not without dread.)

The intensity of the tie between patient and therapist, developed in an atmosphere (at the beginning, at least) of great anxiety and a situation of frustration from which there is no ready escape, may resemble that between infant and anxious mother. This last is suggested by the observation that patients seem to be strongly attached to people and situations that would in the ordinary sense seem to be noxious. Despite the anxiety and destructiveness in such circumstances, patients—and others—return to them and find it difficult, if not impossible, to break the ties which hold them. In brief, the tie that binds most closely has woven into it threads of

anxiety and cruelty, and similar components—real or "transference"—may be found in the treatment itself.

The Range of Emotional Response

There are relationships maintained over long periods of time and felt to be of great significance in one's life, despite the fact that the encounters of the participants are brief, formalized, and stereotyped. Thus it was with a man at a filling station which I visited for service once or twice a week for twenty years. Our exchanges were friendly but perfunctory, were concerned with the business of my car, and there was little revealing of self to the other. We have not seen each other for some time now, and I can't say that we "know" each other in any personal sense. I'm not sure that I'd like him if I knew him better, and I have no true desire to meet with him again. Nonetheless, I recall him well, and I think of him as a friend—which is not exactly the case. Let us say that I am "attached" to him; he is significant in my life.

In contrast to the relationship with the garage man, that with the [036] patient is noteworthy for both the intensity and range of emotions brought to awareness during the period of work. On occasions these passions are deeply felt and cannot be dealt with by an attitude of cool detachment. Without a minimum of such feeling, the therapeutic—human—attachment is not likely to be strong.

Let us return now to Jane's remarks at the beginning of this account. She had said that my wife and I seemed close to each other and was surprised at Gwen's idea that Jane and I spoke in a way that seemed strangely personal and different. Where did this "difference" lie? To put it simply, my wife and I care for each other, take pleasure in our children, and share our living willingly and without regret. We have our differences, we can hurt each other, at times we get angry, we know tenderness, and we have no serious illusions about being proper models for others to emulate.

However, the home—with good fortune—is not usually just like the hospital. My wife had expressed confidence and trust in me from our



earliest meetings; she anticipated that good rather than evil would come from our being together. She did not again and again call me obscene names; she did not attack me physically and seriously attempt to kill me; she was not found mute, lying on the floor incontinent, wet, and soiled; she did not rapidly swing from one mood to another without obvious cause, and her behavior was not so unpredictable that I could not know what might come next; she did not repeatedly threaten to desert me and to kill herself; she did not ignore me, or deride me to others, or run from me without explanation; she did not picture me as a striking reduplication of some relative or a figure in the phantasmagoria of hallucination; and she did not look upon me as deceiving her and plotting to destroy her.

But all of these—and more—were characteristic of the relationship with Jane. I am glad that such tempests have been spared us in the home, although I know that they can exist there as well as elsewhere. Had my wife dealt with me in this fashion early in our days together, I think that we should soon have gone different ways. With Jane, however, all of this behavior had to be faced and attempts made to comprehend it in terms of the present and what had gone before. Jane often called me cruel and spoke of herself as cruel and destructive. At times I felt cruel and wanted to get out of a situation in which I felt more like a jailor than a physician. But I did not leave, and despite her protests, Jane remained also. Neither one of us could leave; we came to feel bound to each other. But this binding together could not continue—as it does in some families—throughout years of mutual destructiveness, maintained by a subtle fitting of pathological [037] needs and ending or subsiding through exhaustion, death, or discouragement and apathetic withdrawal. Once formed, the bonds had to be understood, loosened, and modified so that separateness could be attained. Early in our work Jane put the matter simply: "I think that we are going to be responsible for each other—maybe forever. Sometimes I think you'll kill me—or I'll kill you. Or maybe I'll get better—and if I do, you'll change also." She did get better—and as is always the case, I think, I also changed through this experience.

I shall not attempt here to state the details of the changes undergone either by myself or the patient. I am attempting rather to describe something of the nature of the relationship which is experienced as unique and which is a factor, I think, in leading to changes in the participants. Although I had been myself in personal analysis for some years at the time of this last experience, I did discover "within myself"—as the saying goes—previously unrecognized qualities of anger, fear, tenderness, and affection. I came to understand more clearly that I often wanted to escape from the impact of another person's anxiety and psychotic behavior, and thus might attempt to deny it or to shut it off to the disadvantage of my patient and her therapeutic needs. I found aspects of myself reflected in her own behavior, and at times such realizations seemed almost intolerable. Sullivan's phrase "We are all more simply human than otherwise" came to have greater meaning to me, and I was more accepting of my own current limitations without the need for denial, fear, or shame. I also learned more about how easily I myself might resist personal change, as did my patient, and how apprehensive I could become about separation from people, from objects, and from characteristics of my own. I trust that these remarks do not appear to be casually sentimental. They are not intended as such. Although the therapist experiences personal change through his work, he is required to be so expert that he can endure this and focus on his primary task—facilitation of his patient's growth. He is not free to wallow in unnecessary preoccupation with himself or a narcissistic concern with his own needs and the intricacies of his personality. I suppose that in some ways this last could be said about a parent who is to a considerable extent responsible for the growth of his child and yet grows himself in his living with that child.

I suggest that the exposure of a wide range of emotions—including anger, fear, repulsion, disgust, tenderness, lust, compassion, and so on—in a situation to which limits are set, frustration endured, and understanding sought—serves to intensify and strengthen the bonds of relationship. [038] Although we speak of these strong emotions as being experienced often as



"real" and not assumed, they are brought forth in a particular setting designed to be therapeutic and are not carelessly invited because of some alleged beneficial "cathartic" effect. Despite the terms used, therapeutic contacts are not in themselves amusing or dramatic; they are a form of hard work designed to free a person of the past's nightmare and leading to eventual separation of the participants. This is not the case with one's wife, for example. I am a selfish person. I do trust that my wife and I shall benefit from our relationship, but we seek pleasure in it, as well as growth, and it is not designed to lead to our separation—except through our errors or the end of life itself.

Here again the question can be raised as to what there may be in a therapist's own background that may interest him in—and hold him to—such work. Many people would want no part of all this. I doubt that one would become or continue as a psychotherapist of schizophrenic patients without having been aware of distress in his early family life and without knowing at times intense anxiety in his relationships with others. There often is a need to find in others a further understanding of himself, and the schizophrenic way of life is a startling caricature of man's compounded desire for relationship and his fear of it, his goodness and his evil, his creativity and his destructiveness, his freedom from instinctual control and his subjugation to education and learning, and his power to form and use symbols that could lead to his end as well as his continuance.

Sometimes a therapist may seem to be driven to "cure" his patient, as if his own survival depended upon bringing about change in someone else and in "making sense" of a tumultuous and confusing scene. Such motivations can arise from a child growing up with an anxious and disturbed parent—probably mother—whose distress he felt impelled to reduce in order to guarantee her survival and thus his own. It is the business of the therapist to know about himself, at least to the extent that he does not impose on his patient needs that must be understood and met elsewhere—as in personal treatment and continuing consultation regarding his work.

The Form of Contact

Therapists vary in their practices, but with the patient who is at times grossly disturbed, analytic niceties cannot always be maintained—nor should they be. Often there may be brought into play a wider range of contact than is found in the usual office setting. Some of these will be mentioned here—but briefly. [039]

Sound

The range of sound is wider in this work than in more conventional psychotherapy. If the patient is met with in his hospital room, there will be no soundproofing to keep out the noise of the surrounds, and the patient's world in the institution will become very much a part of the treatment—often with beneficial results. There may be periods of muteness that contrast with the shouting of other times. The therapist himself will not always speak in carefully modulated tones but may find himself attempting to shout down his patient in an effort to disrupt some psychotic outburst.

Touch

Except for the formality of an occasional handshake, there is little, if any, bodily contact between therapist and analytic patient. I am aware of the use of such contact by therapists who advocate massage, holding the patient, bottle-feeding him in states of regression, and so on. A therapist must work in accordance with a theory which makes sense to him and within the limits of what is suitable to him as a person as well as potentially profitable to his patient. It is not suitable to my style to proffer physical contact as being in itself healing. However, I hopefully do not recoil from such contact when its expression is spontaneous and its refusal will be experienced as affront.

For example, a woman patient suddenly stopped her pacing about the room, sat on my lap, and clung to me weeping; all of this after I had commented on her isolation and the great distance that seemed to separate us. I put my arm around her, and we sat in silence for a time until she slid to the floor beside me and spoke of her loneliness. Sometimes I sat beside a mute and catatonic patient and rubbed her back until



the rigidity of her muscles relaxed and she could be more at ease. Frequently, I have been impressed by the seeking for bodily touching being disguised as assault. Thus a patient would hit at me and then briefly cling to me before withdrawing his hands. The use of wet sheet packs, continuous tubs, massage, and showers are useful ways of providing stimulation to the skin that is greatly needed by many who have had little of such comfort since infancy—if then.¹⁷ [040]

Sight

The anxious schizophrenic patient fears not only the relationship into which he is invited but also its loss. Although such a person may turn his head away and hide his face, he needs to be able to look at the therapist at times to reassure himself that the "object" is not leaving him. Frequent visual contact with the therapist and the contents of the office is required for orientation and for the building up of a reassuring and persistent gestalt or picture in which the patient can find a place for himself. To look at the ceiling or one wall from the vantage point of the couch is not enough, and the sharing and exploring with the therapist of a broad range of visual and other patterns may become a useful symbolic reduplication of experiences in earlier developmental eras.

Motion

There is more movement in these treatment procedures than in those that are more formal. The patient may be too restless to sit and may move about the room; at times patient and therapist may walk together. With such activity an additional dimension is added to the therapeutic experience—kinesthetic sensation. The person who has become estranged from himself may gain an increasing awareness of the unity of his existence as he feels the movement of his body in activity shared with another.

¹⁷ On this subject see, for example, the following: L. K. Frank, "Tactile Communication," *Genetic Psychology Monographs*, 56 (November, 1957), 211-255; H. F. Harlow, "The Nature of Love," *The American Psychologist*, 13 (1958), 673-685.

Odor

There is little variety in the usual smells of a therapist's office, and we soon grow accustomed to what little there is. The range of odor may be greatly increased in working with a disturbed patient who may bring feces, urine, and food into the situation in ways that may be disconcerting yet revealing.

The forms of contact briefly mentioned here are more common in infancy and childhood than in later adult life. We tend to "out-grow" and restrain these expressions, but we should not forget their communicative aspects or our often poorly concealed need for renewed contact with them. They can be powerful reminders of our past—as both child and parent—and their sharing can greatly intensify the bond of relationship.

In more conventional office therapy these contacts are restricted or muted in the service of social requirements and the facilitation of introspection and reverie. Such limitations may not be possible—or desirable [041]—with some patients, and ways must be found to make use of the behaviors that are available. Although I have no great sympathy for a careless disregard for convention—social and professional—I think it necessary for the therapist to be fully aware of any personal, anxious withdrawing from expressions of human relatedness as so briefly noted above. Such aversions may close off or leave undiscovered the only remaining ways to the fading hopes of another person.

Transference

It is characteristic of the schizophrenic person to invest his associates with attitudes derived from his own past without correcting these through a careful observation of what is occurring in the reality of the present. Such perceptual distortions—transference phenomena—often have a protective quality in that current figures are seen in terms of past and known dangers and thus avoided as potential sources of harm. The accompanying difficulty, of course, is that the person who has become so sensitive to the faintest warnings of danger may attack or flee so rapidly that he never notices that the threat is minimal



or nonexistent.

The therapist may be seen in many guises—usually more fearful than benign. He is dealt with as a violent man, a seductive rake, an embodiment of evil, or occasionally as a good person endowed with more than his actual virtues. The transference distortions may be presented with such intensity and conviction as to seem real, and under persistent assault the therapist may feel pulled out of himself and find it difficult to distinguish clearly between who he is and what he is alleged to be.

The patient, suspicious of all who come near him and anticipating harm, must search carefully for any sign of deceit, hypocrisy, evasion, cruelty, or whatever in the therapist. In the more conventional task of therapy the patient's "ego strength" is judged sufficient to distinguish between distortions of the present governed by his past and the truth of the moment. With the schizophrenic person, active assistance must be given in this task of sorting out the private component of perception from that which can be validated with others.

The therapist himself becomes an object of this sorting process. That is, he is searched to find that which rings true and that which does not. Thus it is that he is exposed more thoroughly and ruthlessly than in other therapeutic encounters, finding that his "real" as well as his "transference" [042] self will be revealed. The therapist's consistency over a long span of time is not to be found in "being the same" from one session to another, but in being "whole" in each session; that is, he is one in his action, feeling, thought, and speech, giving out none of the "mixed messages" that confuse the recipient to such an extent that what is felt as hate is labeled love, distance closeness, and the command to be free leaves the listener faced by the necessity to resolve a "double-bind."

Often the perfection of these therapeutic tasks is not achieved. The therapist does not always ring true, he will on occasion give out mixed messages, and he may catch a patient in a net of double-binding, as he himself is often caught. Over the long stretches of time required in some instances, the therapist will vary in the exhibition of his skills, being more competent at some times than at others. In all of this he will

be revealed, not only as a professional therapist, but with increasing clarity as the person he is.

In "real life" there may be no great quarrel with the maintenance of some illusions. Love, which has been said in frivolous (or even serious) moments to make the world go round, has usually been supported and maintained by illusion. In therapy, however, illusion is to be revealed, given its due of respect, and put aside. This attempt to forego illusion and to discover what "is" (even with the recognition that reality itself is not readily defined) is with time shared by patient and therapist. The effort to find and know "truth" is the basis of a mutual respect even though the proposed goal is never reached.

The relational bond is formed and strengthened in this search. The therapist is not simply divested of transference adornments and finally revealed as being nonexistent. Rather does he emerge as a person, with his strengths and weaknesses recognized and accepted for what they are. Early in their relationship the participants may view each other as "objects" rather than persons, this tendency being reinforced by the presence of anxiety. One may be depersonalized as "a schizophrenic" and the other as a "shrink." As the therapist looks for the person in the patient, he is himself explored, attacked, manipulated, searched, and seemingly torn apart in a hunt for inconsistencies, incongruities, and imperfections. Such seeking— if endured—should lead to the transformation of object into person and the development of trust and confidence that will permit the final separation without undue distress. In this process of transmutation the bond between the participants is further toughened. [043]

In Conclusion

The therapeutic relationship is sometimes described as having a quality of friendship. A friend can listen, sympathize, advise, reassure, understand, comfort, tolerate, and to an extent reveal himself. However, he wants for himself sympathy, reassurance, and so on, and the seeking of such satisfactions will require him to ignore some aspects of the relationship or imagine



others that do not exist. The goal of friendship and love—for the most part, at least—is not change, growth, and separation. Friend and lover often wish to keep the other one "just as he is," perhaps hoping that in so doing the passage of time itself can be defeated.

In contrast the therapist (and also the parent and teacher) seeks in part the fulfillment of his needs through the facilitation of another's growth, the achievement of which leads to change and separation. The therapist acquires a range of tolerances not easily maintained; involved, he is detached; alone, he is close; expert and experienced, he accepts the limitations of these terms; with change he is constant; and seeking to mold another, he is to an extent molded. His experience, training, and technique

become a part of himself, there then being no gross separation of the personal from the professional. It is this combination of self, experience, and indoctrination that is presented to the patient for his investigation, manipulation, and contemplation—the transactions through which his own self-knowledge and growth can be furthered.

The therapist is not an "object," a friend, a lover, a transference figure, a teacher, or whatever—nor even a combination of these, although representations of each may recurrently seem to find transient support in his being. He is not like something else; he is a therapist, and the relationship with him reflects many aspects of living but is itself unique. [044]

He considered the patient's development of erotic interest in the therapist to be a useful part of the psychotherapeutic process because denial of these desires would demonstrate to the patient "the impossibility of conducting life on the pleasure principle."⁹ He thus thought that any satisfaction of the patient's erotic interests was destructive of her "susceptibility to influence from."Â Most modern psychotherapists who have written about sexual contact between patients and their therapists also have opposed it categorically. For them, and for the major professional psychotherapists' organizations that have issued absolute prohibitions of the activity, the main concern is that the therapist may lose his objectivity and exploit the patient. Patient suicide is a source of considerable anxiety for psychotherapists. It is experienced by a substantial number of therapists, and has a significant emotional impact when it occurs. A survey of 105 therapists forms the basis for the author's report on the frequency of patient suicide and its impact on therapists, according to the phases of their reaction. Methods of coping with patient suicide, particularly group support and training that anticipate such an experience, are described. Of particular note are some survey respondents' comments on lessons they have learned from a patient's suicide. These experts establish interpersonal relationships with the patient to help out in their problems. They talk and assist the patient, depending on their method of therapy. You can read more about this topic since only basic information are given here. Summary: 1. Psychology is a field of science that deals with a person's mental state and behavior. 2. A psychologist undergoes years of study, earning a license, to talk and interpret, advise, and assist patients increase their outlook in life.Â A psychotherapist, on the other hand, is one who specializes in healing the psyche. Contrary to the author above, a psychotherapist does need to be licensed and/or registered in all states. You need a Masters degree. Reply.