Chapter 11

INTEGRATION AND DIFFERENTIATION IN SCHIZOPHRENIA: AN OVER-ALL VIEW (1959)[1]

FROM a phenomenological viewpoint, schizophrenia can be seen to consist essentially in an impairment of both *integration* and *differentiation*, which, as I shall attempt to show, are but opposite faces of a unitary process. From a psychodynamic viewpoint as well, this malfunctioning of integration-differentiation seems pivotal to all the bewilderingly complex and varied manifestations of schizophrenia, and basic to the writings on schizophrenia by Bleuler (1911), Federn (1952), Sullivan (1947, 1953, 1956), Fromm-Reichmann (1950, 1952), Hill (1955), and other authorities in this field.

The term 'integration' is used here in an inclusive rather than highly limited sense; I shall discuss integration as a process which pervades multiple personality levels and personality areas. This paper is intended to be relevant to integration of the self-image, integration of one's experience of the surrounding object-world, integration of ideational content with affective impulses, and so on. The term 'differentiation' is employed here in a similar general sense and I am interested in differentiation as taking place in these same numerous areas of personality structure and personality functioning.

The term 'differentiation' is intended to bear the dual connotation conveyed, as I understand it, in common psychoanalytic and psychiatric usage. It connotes, as in biology, the elaboration of distinctive, specialized characteristics of structure and function as well as an ability to distinguish between, or to discriminate, fundamentally different objects and experiences. To take an example, this dual connotation operates when we say

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that a relatively mature person is capable of achieving a highly differentiated conception or image of another person. This would imply both that he is relatively well able to grasp the highly complex, special ramifications of the personality of the other, and also to distinguish between that personality and other personalities with whom he has had experience.

Taking the matter of *integration* first, we find that when we assess the schizophrenic individual in terms of the three classical Freudian 'compartments' of the personality–id, ego, and superego–we discover these three personality areas to be poorly integrated with one another. The id is experienced by the ego as an intensely inimical foreign body, which threatens to be overwhelming. In the more normal person it is rather a repository of primitive drives towards which one can maintain a basically friendly and receptive attitude, and which represents priceless wellsprings of energy. The ego itself is severely split in the schizophrenic, as many writers have described, sometimes into innumerable islands which are not linked discernibly with one another. The superego, rather than being, as in the normal person, in the relation of a firm but friendly and helpful guide to the ego in the latter's efforts to cope with the id-impulses and with the outer world, stands in the nature of a cruel tyrant whose assaults upon the weak and unintegrated ego are, if anything, even more destructive to it than are the accessions of the threatening id-impulses (Szalita-Pemow, 1951). Moreover, the superego, even in itself, is not well integrated. Its utterances contain the most glaring inconsistencies from one moment to the next, entirely comparable with a parent who is not only punitive but bewilderingly inconsistent. Jacobson (1954*a*, 1954*b*) has shown that there is actually a dissolution of the superego as an integrated structure, and a regressive transformation back into the threatening parental images whose conglomeration originally formed the superego.

With this structural state of things existing in the personality of the schizophrenic, it naturally follows that he functions in a poorly integrated fashion. When we perceive him in a temporal dimension, we find that he cannot integrate his life-experiences over a span of time as being all part of a continuing, unbroken pattern. Instead, his present and past experiences become all jumbled up, in the way which Federn (1952) has pointed out in

his description of the phenomenon of regression to earlier ego-states. When we perceive him in the dimension of immediate interpersonal experience, we find that rather than his having an integrated over-all emotional orientation towards the other person, his reactions to the latter are, instead, an uncoordinated welter of ambivalent feelings–feelings which suddenly erupt, or as suddenly become unavailable to him through repression, in a fashion which severely limits the possibility of his developing a continued, integrated interpersonal relationship.

Differentiation is a process which is essential to integration, and vice versa. And when we look at this process of differentiation in the schizophrenic person, we find it to be similarly severely impaired. It is difficult or impossible for him to differentiate between himself and the outer world; his ego-boundaries are unstable and incomplete. He often cannot distinguish between memories and present perceptions. Memories experienced with hallucinatory vividness and immediacy are sensed as perceptions of present events, and perceptions of present events may be experienced as memories from the past (which may account for many instances in which schizophrenic patients speak of events in the immediate situation in the past tense). He may be unable to distinguish between emotions and somatic sensations; feelings from the emotional sphere often come through to him as somatic sensations, or even as variations in his somatic structure (changes in the size, colour, and so forth, of bodily parts).

Hartmann (1939) made this interesting point in regard to the early development of psychic structure: '. . . there is no ego before the differentiation of ego and id, but in the same sense the id does not yet exist either. Both are products of a differentiation process.'

He has difficulty in differentiating, perceptually, one person from another, so that he is prone to misidentify one person with another; part of this misidentifying often involves his experiencing transference phenomena not only at an unconscious level, as does the neurotic, but at a conscious level. He may *consciously* experience the therapist as being, for instance, his father or mother or brother. In the conduct of his daily life and in his communicating with other persons he is unable to distinguish between the symbolic and the concrete (Bateson, Jackson, Haley and Weakland, 1956). If the therapist uses symbolic language the patient may

experience this in literal terms. On the other hand the affairs of daily life (eating, dressing, sleeping and so on), which we think of as literal and concrete, may be reacted to by the schizophrenic patient as possessing a unique symbolic significance which completely obscures their 'practical' importance in his life as a human being.

In this paper I shall make a general though necessarily brief survey of some of the aetiological factors at the basis of the schizophrenic's impairment of integration and differentiation, some of the manifestations of this impairment as shown in his ward-group relatedness and in the patient-therapist relationship, and in both these contexts I shall examine certain therapeutic measures, with particular reference to the ways in which they foster the resolution of this schizophrenic impairment.

Aetiology

This central difficulty in schizophrenia–the impairment of integration-differentiation–seems to be most fundamentally attributable to the schizophrenic's regression to the level of early infancy, at which developmental phase the infant had not yet become subjectively differentiated from the outer world; a phase in which he felt himself to be, instead, at one with all the world which came within his ken–a world much too vast for his rudimentary ego to integrate. This point has been conveyed by many writers–by Ferenczi in 1913 (1950), Nunberg (1920), Stärcke (1921), Federn at least as early as 1927 (Federn, 1952), Schilder (1935) (to mention only a few of these early investigators), and by many others in more recent years. One very recent work which illuminatingly traces this theme is the volume entitled *Chronic Schizophrenia*, by Freeman, Cameron and McGhie (1958).

In the most general terms, normal psychological development consists in successive stages of personality differentiation, each such stage being grounded in a newly won integration. Thus a reasonably healthy intra-uterine development is necessary to the earliest post-natal existence; a symbiotic relatedness between the infant and the mothering person is essential to the differentiation of the infant's own ego as distinct from the world about him; an effective level of non-verbal communication between infant and mother must be established before the beginnings of verbal

communication can emerge in that relationship; and reasonably reliable verbal communication must be established, at a concrete level, between the child and those about him, before he can achieve the still more adult differentiation between concrete, literal thought and speech on the one hand, and abstract, metaphorical thought and speech on the other. In adulthood, similarly, we find that the better a person's integration, the more richly differentiated can his personality be–just as the tallest, most luxuriant tree is that with the most extensive root system, embedding it firmly in the nourishing earth.

When we look, in terms of this developmental sequence, at the life-history of the schizophrenic, we find that many writers–including Reichard and Tillman (1950), Lidz and Lidz (1952), and Limentani (1956) to mention but a few–point to the existence of a symbiotic relatedness between the patient and his mother as being the most fundamental cause of his later schizophrenia. But Benedek (1949, 1952*a*, 1952*b*, 1957) has stressed that a symbiotic relationship between infant and mother is *necessary* to the healthy development of the infant, as well as to the maturation of the mother herself. Mahler (1952) has found, in work with schizophrenic children, that the most deeply ill are those in whose relationship with their mother a symbiotic relatedness never became established; and my work with adult schizophrenics of various degrees of illness (1959) supports her observations.

What *is* pathological in this connexion, in the schizophrenic's life-history, is, as Mahler (1952) has stated, the circumstance that this symbiotic relatedness never became established, or became established but was not resolved in the normal way in early childhood.

Since the most significant traumata in the schizophrenic's life-history are generally conceded to be very early ones, I shall dwell upon the pathological circumstances obtaining in infancy and early childhood, and shall discuss further the relationship with the mother, before widening my focus to include aetiological factors in the family as a whole and, finally, in the over-all culture.

The mother is typically a deeply anxious, precariously integrated person whose chronic anxiety is probably intensified in her dealings with her young infant by reason of the symbiotic relatedness–with its concomitants of mutual incorporation

(Searles, 1951) and poor definition of ego-boundaries–which the infant needs, and therefore strives to establish with her. Thus, in the relationship with the infant her own personality disorganization is probably even greater than usual. One particularly poorly organized, changeable mother was described by her non-schizophrenic eldest son as typically coming home from the Baptist church on Sunday morning in a beatific state of religious exaltation, and the next moment furiously throwing a kitchen pot at one of the children. Her schizophrenic daughter insisted for years, in her therapy with me, that she had had not one but many mothers, and once explained to me, 'Whenever you use the word "mother", I see a whole parade of women, each one representing a different point of view.'[2]

It is not surprising that some of these precariously integrated mothers shy away from entering into the necessary symbiosis with their young infants. And to the extent that they do enter into it, the infant's needs tend to be subordinated, as Hill (1955) has beautifully described, to the personality-needs of the mother. This has been considered by Bateson *et al.* (1956) as being a matter of the mother's hatefully holding the growing child fast in this symbiosis, through 'double-bind' injunctions, such that he feels damned if he does, and damned if he doesn't, say or do this or that. But my own work (chapter 7) has shown that an even more powerful reason for the continuance of the symbiosis into the offspring's chronological adulthood resides in his basically loving and loyal sacrifice of his own individuality in order to preserve the mother's unstable personality equilibrium. He senses that his own sick personality functioning dovetails with hers in such a way as to keep her head above water.

Particularly does the child bear the brunt of the mother's various massive dissociations, and from our own experience in therapy we know how alone and anxious it makes us feel to be aware of powerful emotions in the other person of which he himself is unaware. It took me several years to realize that, for example, the rape which schizophrenic women fear is, above all, rape by the mother who unconsciously fantasies herself as possessing a penis–a fantasied penis, that is, which is dissociated in the mother herself.

The mother, being a far from whole person, because of the

[2] Described on p. 306 also.

dissociation of large elements of her personality, is unable to respond to the growing child as being a whole and separate individual. Thus we find her focusing unduly much upon certain anatomical parts or personality attributes of her child, and blotting others out of her awareness–all of which greatly interferes with his developing a conception of himself as being a whole person. Hence, the adult schizophrenic patient may view himself, as one of my patients put it, as being 'a conglomeration of things'. Storch (1924) reports that one of his patients described himself similarly as being a 'conglomeration'.

The child's personality fragmentation may be heightened, further, as a defence against the inordinately strong incorporative needs of the mothering person, whether this latter be the mother, the father, a nursemaid, or whoever. One patient for example felt for years in childhood as though the top of his head were gone. This incompleteness of body-image was eventually found, in psychotherapy, to be in part a reaction to the invasive curiosity of his nursemaid. It was as though the only sure way to keep her from reading his mind were for much of his psychological life to be barred even from his own awareness, and this, translated into corporeal terms, gave him to feel that the cranial area of his head was missing.

In broadening my focus to include the family as a whole, let me stress that the normal infant, and the schizophrenic-to-be child, is not able to differentiate himself fully from his environment, either from other human beings or from the inanimate objects in it (Searles, 1959). Thus we can understand how fragmenting it is to his developing personality for him to have, as often happens, a bewildering succession of mothering figures or many changes in residence, or for him to be exposed to intrafamilial relationships or marked dissension. He cannot incorporate usefully the personality ingredients of two parents whose interpersonal relationship with one another is a very poorly integrated one–parents who seem (in some instances when one interviews both together) to function almost without any coordination at all, even an antagonistic one. Thus, at an intrapsychic level in the child, introjections from the mother cannot be well integrated with introjections from the father.

Further, as has been described by Wynne and his colleagues (1958), the actually great intrafamilial antagonisms are, by a

kind of unspoken mutual pact, denied in the family, and a front of family oneness presented.

The paper by Wynne and his co-workers details, in an illuminating fashion, some of the means by which this family 'pseudo-mutuality' thwarts the child's differentiation–differentiation either of his personal identity or of his view of the world around him. In my experience, some of the families of schizophrenics make as great a fetish, by contrast, of what one might call pseudo-*non*-mutuality; Dr Joseph D. Lichtenberg emphasized this aspect of the matter on hearing a preliminary draft of this paper.

One of my patients, for example, came eventually to tell me proudly of 'those crazy Randalls' (her parental family), and seemed to share in a general family pride concerning the chaotic discord which overtly permeated the family, and which overlay a very deep sense of family *coherence* that, in my patient at least, had been deeply repressed at the beginning of her psychotherapy.

It may well be that the kind of family background which I detail above, and which is described in other respects by Wynne *et al.*, is especially true for those patients in whom non-differentiation is the great problem; for those who show personality fragmentation as the predominant problem, as did the woman just mentioned, this opposite kind of family mores may be more typical.

It should be noted that this tends to blur the real individual differences of the members of the family, such that the child does not find, presented to him in the family, real acknowledged individuals with whom to identify. He grows up instead thinking of himself as simply a part of the supposed wholeness of the unitary family, undifferentiated from it. He grows up assuming that it would be unpardonable disloyalty, and lack of love for 'the family', to differentiate himself from it. In such a family, the meaningful one-to-one interaction which any growing child needs with others in the family cannot flourish and be acknowledged as such, for this is again tantamount to the two individuals' mutual disloyalty to 'the family'. Thus such interaction, which lacks consensual validation, tends to be dissociated, like the existing dissensions in the family which the patient tends to introject. In the latter regard, one of my schizophrenic women

patients once gave me to realize that, in the midst of a furious upbraiding of me, she was misidentifying herself as her mother, and me as the mother's son. She thus beautifully revealed her prior introjection of the conflict between her mother and her brother.

If we keep in mind that, in all this, the growing child's ego is not fully differentiated from the personalities of those around him, we see that he dare not experience his feelings of *loss* as such feelings tend to arise, for this would be, as R. A. Cohen has pointed out (in a personal communication), equivalent to loss of his own ego. Thus the pattern is set which is followed in later life, of pathological guarding against loss: the patient cannot relinquish interpersonal relationships which are incompatible with one another, cannot face the loss of any of these relationships, because he dare not face the threat to his personal identity which the attendant separation anxiety and grief would bring. Thus he moves, as he becomes adult, into a galaxy of interpersonal situations which are so incompatible among themselves that *anyone* trying to lead such a way of life *must* be schizophrenic. For example, part of his personality may be invested in a marriage, another part in an extra-marital relationship with another woman, another part in a 'friendship' with the other woman's husband; or he may try to have two fundamentally incompatible relationships with one person. For example, he may be involved with a woman co-worker in a romantic relationship which is quite fully compartmentalized from the co-worker relationship which the demands of their job require them to maintain.

What I am saying here applies especially to borderline patients. Among these persons too, one finds, not uncommonly, instances in which the patient is pulled apart, so to speak, by diverse career interests. He may be pursuing several quite different major career interests concomitantly, unable to relinquish any of them.

In the instances of more deeply ill schizophrenic patients, who are unable to form such contacts and career interests outside the family, we find, more frequently, that the patient is trying to develop and maintain fundamentally incompatible relatednesses with a family-member. This is most often, of course, with the mother or father, in whom he is trying to find, simultaneously, not only a parent but also a bosom friend, a spouse, a child, and

so on. This latter kind of multifarious striving for diverse, basically incompatible kinds of relatedness is reproduced, in an intense form, in the transference-relationship to the therapist. Part of the therapist's function is now to help the patient to realize which of these strivings must be directed towards other objects; and to realize that *to a degree* these various strivings are *not* totally incompatible with one another–to realize that, at a feeling level though not in behavioural terms, loving relatedness means that each person is all persons and all things to the other.

These simplified examples illustrate what is really a much more complex pattern, in which one sees that the patient's ego is not merely *stretched* widely into diverse and mutually incompatible relationships, but that it functions as separate islands, and *must* function so in order for such a way of life to continue. And the 'relationships' to which I refer are not so much true interpersonal relationships as identifications with the other persons–investments of ego-identity in these diverse, mutually incompatible interpersonal situations, with a consequent lack of inner integrity, of continuity of identity and of the sense of being a whole person. Erikson (1956) has pointed out that normally this challenging task is met, and accomplished, in adolescence. He says that

> The final assembly of all the converging identity elements at the end of childhood (and the abandonment of the divergent ones) appears to be a formidable task. . . .
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> . . . the adolescent, during the final stage of his identity formation, is apt to suffer more deeply than he ever did before (or ever will again) from a diffusion of roles. . . .

I have tried to show that the adolescent who goes on to become schizophrenic has had so little continuous relatively unanxious well-integrated interpersonal experience, that he has not now the strength to face the separation anxiety and grief entailed in the relinquishment of such incompatible (or as Erikson calls them 'divergent') identifications. He cannot make the necessary renunciations for his ego to become consolidated into a whole, well-integrated, undiffuse one. Another way of putting it is to say that he cannot therefore develop an integrated way of life.

To broaden our focus concerning aetiology to include finally pathogenic elements in the culture, we should note that a culture

in which more than one-quarter of *all* hospital beds are occupied by schizophrenic patients[3] is a culture which presumably contains important schizophrenigenic elements, irrespective of the individual's particular family constellation. Fromm (1955) has described many such cultural elements in *The Sane Society*, which shows how various aspects of our technological culture foster in man a sense of alienation from himself, from his fellow man, and from the products of his work. Two of the consequences described by Fromm are what one might describe as man's inability to become subjectively differentiated as a human being, and his inability to feel a sense of deep participation in the wholeness of collective mankind. His existence is thus both fragmentary and poorly differentiated subjectively from the inanimate instruments and products of the technological culture which permeate his life.

Benedict (1938) has given a few extremely interesting examples, among many possible ones, of the ways in which our particular culture imposes psychological discontinuities upon the developing child and adolescent, discontinuities which many so-called primitive societies do not intrude upon him. She notes, for example, that whereas in our culture one is expected to be obedient and submissive in childhood, and rather abruptly become quite oppositely assertive and dominant on reaching adulthood, many cultures do not expect any such opposite behaviours at these different developmental phases. She notes, too, that many cultures do not require the marked shift in attitudes towards sexual behaviour which are required in our culture, as between the supposedly non-sexual boy or girl and the sexually competent man or woman. And by way of contrast to the attitudes towards productive work in our culture, where the individual is expected to contribute little in childhood and, suddenly, much upon reaching adulthood, she describes how the Cheyenne culture met this aspect of development:

> . . . The gravity of a Cheyenne Indian family ceremoniously making a feast out of the little boy's first snowbird is at the furthest remove from our behaviour. At birth the little boy was presented with

[3] This is based upon statistics collected in 1957, which show that slightly more than one out of every two hospital beds in the United States is occupied by a mentally ill patient, and that in New York State mental hospitals, for example, schizophrenics form about 57% of the patient population (National Committee against Mental Illness, 1957).

a toy bow, and from the time he could run about serviceable bows suited to his stature were specially made for him by the man of the family. Animals and birds were taught him in a graded series beginning with those most easily taken, and as he brought in his first of each species his family duly made a feast out of it, accepting his contribution as gravely as the buffalo his father brought. When he finally killed a buffalo, it was only the final step of his childhood conditioning, not a new adult role with which his childhood experience had been at variance.

Sociodynamics of the Hospital Ward

Turning from this brief discussion of the *aetiology* of the personality fragmentation and non-differentiation which are seen in schizophrenia, let us now look at the kind of group-relatedness which the patient fosters, by reason of these symptoms, on the hospital ward. Many writings have dealt with this, and I shall mention only a few notable ones. Stanton and Schwartz's papers (1949*a*, *b*, *c*) and their book *The Mental Hospital* (1954) describe how the patient's fragmentation increases on his exposure to hospital staff who are themselves involved in strongly felt, but not frankly expressed, differences of opinion concerning his management. Their writings understate the degree to which the patient's own personality-fragmenting anxiety fosters such dissension among staff members. An article by Perry and Shea (1957) makes up for this deficiency by showing the tremendously group-fragmenting effect upon the staff of one of the wards at the National Institutes of Health by an extraordinarily anxious and anxiety-provoking, personality-fragmented man. And Main (1957), reporting in a similar vein, has shown how surprisingly strong were the dissensions among veteran nursing staff concerning a number of such patients who had gone through stormy and therapeutically unsuccessful courses at his hospital in England.

Despite these and various other writings on this subject, however, there are a number of points which I have not found in the literature.

The kind of social situation which the ego-fragmented patient tends to foster on the ward can best be seen, I believe, as a process by which both differentiation and subsequent integration of the disparate ego-fragments must take place largely *externally* to

himself, in the persons of those about him, before these processes can be taken into himself. Of interest in this connexion is Sullivan's (1947, p. 10) view, concerning normal personality development, that 'The self may be said to be made up of reflected appraisals', and Cooley's (1909) concept of the 'looking-glass self'. I shall explain this process first in terms of the process of *integration*, since it is only this process upon which, to the best of my knowledge, existing literature touches.

Such a deeply disturbed ward-integration as Stanton and Schwartz, Perry and Shea, Main, and others have described can be regarded as a kind of group symbiosis, comparable with the infant–mother symbiosis but now embracing a group of persons, including the patient and the various members of the staff and fellow-patients involved with him. We see in this group situation precisely the same elements which have been described by Bowen (1956), Wynne *et al.* (1958), myself (Chapter 1 above), and other writers as characterizing the symbiosis between the mother and the schizophrenic-to-be child. It is a mutual entanglement, intensely felt and deeply ambivalent, wherein the other person is sensed as indispensable to one's own existence. The conflictual needs of each of the participants keep the relationship in constant turmoil, and there is an over-all sense of maddening constriction.

In this group relatedness ego-boundaries are indistinct and the various participants function, as the anxiety in this group situation mounts, less in a truly interpersonal fashion than as a kind of unitary psychological organism. This may be crudely compared, in biology, to the human body in which the various different organs–brain, heart, liver, intestines, and so on–are indispensable to the maintenance of the over-all, unitary organism.

This means that the ward situation *looks*, at first glance, utterly unstable; but actually it represents a kind of social symbiosis which meets the neurotic, or psychotic, needs of the various participants well enough for it to endure for many weeks, or even months.

Looking at it from the vantage-point of the patient, each of the significant other persons in this group symbiosis represents not only a transference figure, but also an externalized fragment of his own ego. In this sense, the complex, previously unsorted-out, unintegrated fragments of his own self become painted on

the canvas which the ward situation presents to him. Thus this situation, anxiety-provoking though it is to all concerned, is a necessary preliminary to his *intra*psychic differentiation and integration. Burnham (1956), in a valuable paper concerning misperception (misidentification) of other persons in schizophrenia, emphasizes that a patient's misperception of an aide (for example) as being a composite of figures from various areas of the patient's life, present and past, is a restitutive phenomenon–is indicative of his striving towards wholeness. Burnham likewise stresses the integrative aspects of a patient's misperceptions of the ward staff collectively. We see over and over in individual therapy that a patient becomes aware of a previously repressed fragment of his self only after seeing it first in a projected form, as being a part of the *therapist's* personality. This is the same process, occurring now in a group setting and with diverse projections operating simultaneously, from the patient to the diverse members of the staff.

The externalization goes on because the patient cannot as yet face the anxiety-laden realization that he has *within him* ego elements which are sharply conflictual. Instead, he unconsciously fosters, in the staff, diverse and conflictual views of himself. Instead of his becoming aware of the war within himself he fosters–largely unconsciously–the staff's warring with one another about him. To say that he is consciously 'playing them off', one against the other, is grossly to overestimate the degree of conscious control which he wields in the situation. It is more accurate to think of him as not yet being able to possess a whole ego within his own skin. His ego is only partial, a fragment, such that it is utterly necessary to him that others about him personify various of the other fragments; just as a heart must have lungs and a brain to go with it in order to survive. Parenthetically, we know that somewhat less ill individuals, whose fragmentation is such that they are only schizoid rather than frankly schizophrenic, feel it very important in some instances that their friends be friends also with one another. This can be seen as the schizoid person's need that the externalized fragments of his ego, which are projected upon these various friends, be a continuous ego rather than a split one.

From the staff's point of view also, this group symbiosis, anxious though it is, meets neurotic needs. For those who are in

a 'Good Mother' position, or who personify 'good' aspects of the patient's ego, there are the gratifications of feeling oneself to be a warmer, more loving, better human being than one's co-workers. For those in the 'Bad Mother' position, who represent 'bad' ego-aspects of the patient, there is the opportunity to ventilate pent-up resentments towards one's fellows, resentments which may long antedate the patient's arrival on the ward scene. There is also the opportunity to feel murderous in a relatively free and unalloyed way towards almost everyone else in the situation (including the patient), without any irksome diluents of fondness, compassion, or comradeship. There is, I believe, a deep pleasure in our experiencing *any* feeling in a powerful and unconflictual way, and this social symbiosis is such as to minimize *intra*psychic conflict for all participants–such as to provide for the externalization of each one's potentially *inner* conflicts.

Each member of the staff tends to relate himself particularly to a single one among the fragmented patient's various disparate personality components–tends to see it as though this represented the totality of the patient. The nurse or attendant may assert that 'this is the way the patient *really* is', and feel that only she or he recognizes what the patient '*really* is like'. To the extent that they see the patient with this kind of tubular vision, we can surmise that such a relatedness is enabling this nurse to project upon the patient some unconscious emotion or unconscious self-image which would cause internal conflict if it were recognized as an ingredient of the staff member's own personality. And I do not mean, of course, that they are 'only projecting'. Freud (1922) long ago pointed out that we project upon that which offers us some reality-basis for the projection. But it is presumably such a projective process which causes the various staff members to have a personal stake in the group symbiosis which these patients powerfully tend to foster on the ward.

To return to the vantage point of the patient, we should realize that he needs the 'Bad Mothers' as much as he needs the 'Good Mothers', for the preservation of both 'good' *and* 'bad' objects allows for the preservation of both his loving and his hateful feelings; these feelings being wedded, as I have indicated, to the objects. Both these two broad categories of feeling are necessary to adult living. This simplified good-mother, bad-mother dichotomy is a fundamental step towards the infinite variation,

or differentiation, of perceived objects and felt emotions that characterizes adulthood. If the staff all realized this, there might be a lesser tendency for them–for those in the 'good' as well as those in the 'bad' roles–to become involved in guilt, which in most instances hopelessly complicates this social picture and turns what could have been a step towards the patient's growth into an unworkable ward situation which ends in therapeutic failure and undermining of staff morale.

In any case, to the degree that the staff personnel go on, week after week, in such oversimplified, stereotyped roles, participants in this social symbiosis, they inevitably feel increasingly constricted. The healthy side of them demands something more than this symbiotic functioning as a less than whole person. One wants to function as, and be recognized as, a whole individual, even though this entails one's facing one's inner conflicts. Even the 'Good Mothers' among them encounter increasing frustration within themselves in the face of their constricting social role, a role which forbids their having anything but love, solicitude, and protectiveness towards the patient. Thus there develops a great deal of frustration-rage and consequent murderous feeling among the personnel, not only towards one another but towards the major fly in their ointment–the patient. But this intense rage tends–except, perhaps, in those who occupy the extreme 'Bad Mother' positions–to be maintained largely under repression, as being too threatening to the social structure and to each participant's conception of himself.

I believe that some of the patient's increasingly destructive symptomatology represents in such a situation an acting out of the repressed destructiveness which he senses to be at work in the personnel about him, analogous to the acting out, described by Johnson and Szurek (1952), by the disturbed child who is giving vicarious expression to the mother's own repressed destructiveness. I believe that his typically mounting anxiety is to a degree based upon a realistic fear of the formidably great measure of murderousness which the other participants in the symbiosis come to feel towards him.

In the face of the increasingly intense conflictual feelings which permeate such a group symbiosis, regression deepens, not only in the patient's behaviour but in that of the staff members as well. Not only do his demands become more infantile, but the

personnel's mothering, good and bad, tends to assume more and more primitive forms. Just as he tends to become a suckling, demanding infant at the breast, they tend almost literally to offer him a breast, 'good' or 'bad' as the case may be, rather than provide more adult forms of mothering. There is a nice illustration of this point, although concerning a not-yet-hospitalized patient, in one of Knight's (1953) articles on borderline psychosis. Here we see what I consider regression not only in the patient, who moves nearly into a literally sucking-at-the-breast role, but also in the therapist–a woman dean, who is a self-styled psychotherapist–who moves, concomitantly, nearly to the position of trying literally to give suck to the patient:

> . . . The dean was subject to increasingly demanding expressions of need from the student. Interviews could not be terminated, since the girl refused to leave, and sessions came to be held at the dean's home in the evening and on weekends.
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> The student refused to see a psychiatrist or to go elsewhere for help, and the dean felt cornered. The girl demanded to use the dean's car as proof of her love and trust, and this was granted. Then she began to request that she be permitted to stay overnight in the dean's home, and when this was granted, that she sleep in the dean's bed with her. At times she expressed irrational hatred of the dean and pounded her with her fists. At other times she wanted to be held on the dean's lap and fondled, and this wish was granted also. No real limits to her regressive behaviour were set until she expressed a strong wish to suckle the dean's breasts. Here the dean drew the line . . .

In my experience, frequent and informal meetings of the various staff members who are involved in the care of these patients are of inestimable value, for at least three reasons. First, they provide an arena for catharsis of some of the powerful feelings which have been engendered, so that the emotions in the over-all social group I have described can be kept within manageable bounds of intensity, thus avoiding the total fragmentation of the group. Secondly, they help the various individual members to go on functioning *as* individuals in their work with the patient–as individuals who are relatively free to act upon their own particular feelings about the patient. Thus he is presented with genuine people of various kinds, with whom to identify constructively, rather than being faced with a staff group which is struggling to preserve some pseudo-harmony, some

ostensible unanimity of attitudes towards him, in order to hide their sharply divergent true feelings about him. We see how similar this latter unconstructive ward situation is to the pseudo-unanimity so frequently found in the schizophrenic's family. Thirdly, these personnel meetings enable, again as part of the same process, a genuine collaborative integration to develop within the working group–an integration of different attitudes towards the patient. This is a process which, as I have previously indicated, must take place outside the patient before integration of his own diverse personality fragments can occur *within* him, through constructive introjection of the well-integrated staff group which is working with him.

At the beginning of this paper I described integration and differentiation as being opposite faces of a unitary process. It is useful, however, to conceive of schizophrenic patients as showing a disjointedness between these two phenomena.

This point has been touched upon by Hartmann (1939) in a paper on ego psychology: 'Precocity of differentiation or relative retardation of synthesis may disrupt the balance of these two functions.' And Hartmann, Kris, and Loewenstein (1946) noted that '. . . acceleration of certain integrative processes may become pathological'.

In the normal individual, integration and differentiation proceed simultaneously and in pace with each other as a relatively smoothly advancing unitary process of personality growth. But one can think of the kind of schizophrenic patient I have just described as showing an imbalance between these two part-processes; an imbalance wherein differentiation has temporarily outdistanced their integration, with consequent fragmentation of personality functioning, such as I have described. There is a resultant need for *integration* as the most pressing problem at the point in their development when we see them on the ward and in the therapeutic situation.

By contrast, there are other schizophrenic patients, still more deeply ill than those I have just discussed, whose emotions, attitudes, thinking-processes, and other personality aspects are not yet sufficiently *differentiated*, with the result that they are even more helpless than the former type of patients in discerning, sorting out, and communicating to others, the welter of undifferentiated thought and emotion which is within them.

Freeman *et al.* (1958), noting how relatively unvarying are their descriptions of the chronic schizophrenic patients whose therapy their book details, state, 'It is our contention that loss of individuality is a feature of the chronic patient in the refractory ward.' These are the patients who are unable to express their thoughts or feelings because they quite literally are unaware of–do not 'have'–thoughts and feelings, most of the time. One of them let me know that he felt himself to be in a 'mist'; another, when I taxed her with failing to report any thoughts or feelings and asserted that I could clearly see, from her rapidly changing facial expressions, that there was a great deal going on in her, explained, 'My face thinks, Dr Searles; but I don't think.' And these are the patients who, in their ward-life and in their psychotherapeutic sessions, are mute and motionless most of the time, and who show, at most, only stereotyped repetitive verbalizations or bodily movements. Finally, these are the patients towards whom the staff members tend to have a genuinely unanimous, stereotyped view–a view in which there is, in a sense, not *enough* of the kind of disharmony which is so overwhelmingly strong among these same staff members in reaction to the former type of patient. In other words, these patients tend to go on, month after month and year after year, in a social role on the ward which is as stereotyped, as un-rich and as unvarying as is, evidently, their subjective intrapsychic experience. Here the pressing need is for greater *differentiation* to occur.

For these patients it is well that they be exposed, over the months and years, to a relatively large procession of different staff members, even if this entails a rather rapid turnover of staff. In my experience, these patients are less likely to become further differentiated if they are taken care of by only the same few nurses and attendants, for such veteran personnel tend to stay in their rutlike, stereotyped view of the patient. More often, it is some newcomer who sees in the patient a bit of differentiation which is trying to sprout, so to speak–an additional personality facet emerging – and who therefore finds himself reacting to the patient in a way which is new and unstereotyped, thus bringing to the over-all staff attitude a welcome piece of differentiation. This is essential because just as for integration, the process must take place first externally to the patient, in the staff, before it can be established in the patient himself.

Often there is evidence that, all along, the 'new' potentiality in the patient has been evidencing itself but, being unnoticed by the staff, being therefore not interpersonally shared between any one of them and the patient, it has persisted as a dissociated aspect of his personality, for that which does not gain consensual validation from one's fellows tends to be dissociated from one's own awareness. For example, at Chestnut Lodge we have had for many years a hebephrenic middle-aged man who is quite generally regarded, by the staff, as good old 'Georgie'. The fact that good old, fawning, obsequious, doglike Georgie not infrequently evidences a loud, blood-curdlingly sadistic laugh seems simply not to be noticed by those who are most involved in his care. They apparently likewise dissociate the fact that his stereotyped 'How's everything, Lovey?' is at times said in a tone as if he were disembowelling the person whom he is greeting. If a new attendant were to take full note of this sadistic, hostile side of good old Georgie, and persistently relate himself to that personality aspect, I have no doubt that the staff as a whole would grow to have a more differentiated reaction to the patient, and this presently dissociated sadism would eventually emerge, bit by bit, into his own awareness. The result would be that he would be a more differentiated (and, at the same time, better integrated) personality, both subjectively and as viewed in the ward social setting.

Not long ago, as part of my supervisory work here, I sat in for a half-hour with a therapist, his female schizophrenic patient and the patient's husband and mother. The therapist and the patient had been meeting thus with these two relatives of hers (who were here on an extended visit) for several sessions, and I had heard from the therapist a lengthy description of how these meetings had been going. At the beginning of the session in which I participated, I was immediately struck with the patient's frequent rubbing of her genital area. This was a blatantly obvious act, and was done in a manner indicative of both sexual excitement and anxiety. I soon asked her about this and, with evident relief, she described the embarrassment this uncontrollable, repetitious act had long been causing her. After the session I learned from the therapist that this stereotyped act had characterized her behaviour in each of the preceding sessions, but he had omitted any mention of it in his lengthy description

of these group interviews. Until I began asking the patient about this, she and her relatives, as well as the therapist, had been functioning as though there were a silent, unanimous, pact whereby the group's abundant verbalizations would never refer to this particular behaviour of hers.

For ward staff as well as for the therapist, the highest order of skill consists, in this connexion, in the *timing* of the relating of oneself to the patient's dissociated process; in sensing *at what point* the patient is ready now to face this aspect of himself, or more accurately, in sensing at what point one's relationship with the patient is strong enough to warrant a mutual coming to grips with the dissociated material. Prior to such a time, it may be the ward staff's or the therapist's unconscious intuition which causes one not to take notice of the dissociated processes in the patient; an intuition which tells one that it would be premature as yet, to try to integrate these into one's relationship with him. But in my experience, errors are as often made on the side of postponing this intervention too long, or of never accomplishing it, as on the side of burdening the patient by a premature response to processes of which he is unaware in himself.

It is often the therapist who sees a new potentiality in th patient, a previously unnoted side of him which heralds a phas of increasing differentiation. And frequently the therapist is the only one who sees it. Even the patient does not see it as yet, except in a projected form, so that he perceives this as an attribute of the therapist. This situation can make the therapist feel very much alone and intensely threatened.

I have worked for several years with a hebephrenic man whom the staff had come to view, unanimously, as being a kind of pitiable, charming little boy, endearing with his flashes of robin-like gaiety. He was regarded as basically hopeless because he had been hospitalized constantly, in a series of institutions, for sixteen years, was now in his mid-forties, and in nine years at Chestnut Lodge had shown relatively little change in the social position I have described. But as my work with him progressed, I began to have glimpses of murderousness–of precariously controlled violence–in him. The charge nurse and others of the ward staff did not see this, and the charge nurse even went so far, in her resentment of my jaundiced view of this robin, as to declare that if the patient ever did become assaultive, he would merely

be acting out his therapist's own violence. This placed me in the position of not only being alone in my opinion, but in addition being held totally responsible for the patient's potential violence. And I would have looked in vain to the patient himself for any reassurance on this score, for he was meanwhile misidentifying me, in an acutely threatened fashion, as being 'Pretty Boy Floyd' (a boyish-faced gangster of the 1920's).

On the way to an informal staff conference concerning this situation, I fell downstairs and smashed my head into a wall with a much greater jolt that I ever received in four years of high-school football. It was such a jolt, in fact, that later in the day I obtained skull X-rays and a neurological examination which proved—I must for some reason add—to be negative. In any case I managed to go on to the conference, feeling marked indeed as a violent man by the ward personnel who had witnessed this fall. But the conference, consisting predominantly in the expression of intensely antagonistic feelings between the charge nurse and myself, each documenting our stand with details from our respective work with this patient, proved to be the breaking up of what had been a long-frozen ward-attitude towards him, and I lived to see the happy day when the charge nurse herself became frightened at seeing his murderous side.

What I have just described touches upon the subject of the therapeutic relationship itself, and the severe stresses which the phenomena of schizophrenic disintegration and non-differentiation place upon both therapist and patient.

The Patient-Therapist Relationship

Focusing now upon the transference relationship with the therapist, we find that the patient naturally brings into this relationship, just as he brings into the group-relatedness on the ward, the difficulties concerning differentiation and integration which were engendered by the pathological upbringing I have described. And, as in the ward situation, we find that here too, advances in differentiation and integration necessarily occur first outside the patient—namely, in the *therapist's* increasingly well-differentiated and well-integrated view of, and consequently, response to, him—before these can become well established within him.

Because the schizophrenic patient did not experience, in his

infancy, the establishment of, and later emergence from, a healthy symbiotic relatedness with his mother such as each human being needs for the formation of a healthy core in his personality structure, in the evolution of the transference relationship to his therapist he must eventually succeed in establishing such a mode of relatedness. In Chapter 7 above, and in my book *The Nonhuman Environment*, I have described a few of the many clinical experiences which convinced me of this point.

This means that he must eventually regress, in the transference, to such a level in order to get a fresh start towards a healthier personality differentiation and integration than he had achieved before entering therapy. This is not to say that he must act out the regressive needs in his daily life. To be sure, the schizophrenic patient, whether in therapy or not, inevitably does so to a considerable degree; but to the extent that these needs can be expressed in the transference relationship, they need not seek expression, unconsciously, through acting out in daily life.

This symbiotic mode of relatedness is necessarily mutual, participated in by therapist as well as patient. Thus the therapist must come to experience not only the oceanic gratification, but also the anxiety involved in his sharing a symbiotic, subjective oneness with the schizophrenic patient. This relatedness, with its lack of felt ego-boundaries between the two participants, at times involves the kind of deep contentment, the kind of felt communion that needs no words, which characterizes a loving relatedness between mother and infant. But at other times it involves the therapist's feeling unable to experience himself as differentiated from the pathology-ridden personality of the patient. He feels helplessly caught in the patient's deep ambivalence. He feels at one with the patient's hatred and despair and thwarted love, and at times he cannot differentiate between his own subjectively harmful effect upon the patient, and the illness with which the patient was afflicted when he, the therapist, first undertook to help him. Thus, at these anxiety-ridden moments in the symbiotic phase, the therapist feels his own personality to be invaded by the patient's pathology, and feels his identity severely threatened, whereas in the more contented moments, part of the contentment resides in both participants enjoying a freedom from any concern with identity. In the latter connexion

I recall a contented silence in which a schizophrenic woman and I, lounging in adjacent chairs, were listening to the borborygmal rumblings in our abdomens. At one point, hearing some rumbling, she giggled and said she couldn't tell whether this came from her own 'stomach' or from mine, or from the first floor of the building, below. I wasn't sure either; but, above all, it didn't matter.

This same profound lack of differentiation may come to characterize also the patient's view of the persons about him, including his therapist; and at times, in line with his need to project a poorly differentiated conglomeration of 'bad' impulses, he may perceive the therapist as being but one head of a hydra-headed monster. The patient's lack of differentiation in this regard, prevailing for month after month of his charging the therapist with saying or doing various things which were actually said or done by others amongst the hospital staff, or by the family members, can have a formidably eroding effect upon the therapist's sense of personal identity. But the patient may need to regress to just such a primitive, poorly differentiated view of the world in order to grow up again, psychologically, in a more healthy way this time.

Among the most significant steps in the maturation which occurs in successful psychotherapy are those moments when the therapist suddenly sees the patient in a new light. His image of the patient suddenly changes, because of the entry into his awareness of some potentiality in the patient which had not shown itself before. From now on, his response to the patient is a response to this new, enriched view, and through such responding he fosters the emergence, and further differentiation, of this new personality area. This is another way of describing the process which Buber (in Friedman, 1955) calls 'making the other person present': seeing in the other person potentialities of which even he is not aware, and helping him, by responding to those potentialities, to realize them.

In my experience, schizophrenic patients' feelings start to become differentiated before they have found new and appropriate modes for expressing the new feelings. Thus a patient may use the same old stereotyped behaviour or utterance to express nuances of new feeling. This is identical with the situation in those schizophrenics' families which are permeated with what

Wynne *et al.* (1958) term 'pseudo-mutuality': 'In pseudo-mutuality emotional investment is directed more toward maintaining the *sense* of reciprocal fulfilment of expectations than toward accurately perceiving changing expectations. Thus, the new expectations are left unexplored, and the old expectations and roles, even though outgrown and inappropriate in one sense, continue to serve as the structure for the relation.'

The therapist, through hearing the new emotional connotation, the new meaning, in the stereotyped utterance and responding in accordance with the new connotation, fosters the emerging differentiation. Over the course of months, in therapy, he may find the same verbal stereotype employed in the expression of a whole gamut of newly emerged feelings. Thus, over a prolonged time-span, the therapist may give as many different responses to the gradually differentiating patient as are simultaneously given by the various members of the ward-staff to the patient who shows the contrasting ego-fragmentation (or, in a loose manner of speaking, over-differentiation) I have described earlier in this paper.

Persistently stereotyped communications from the patient tend to bring from the therapist communications which, over a long period of time, become almost equally stereotyped. One can sometimes detect, in recordings played during supervisory hours, evidence that new emotional connotations are creeping into the patient's verbal stereotypes, and into the therapist's responsive verbal stereotypes, before *either* of the two participants has noticed this.

What the therapist does which assists the patient's differentiation often consists in his having the courage and honesty to *differ* from either the patient's expressed feelings or, often most valuably, with the social role into which his sick behaviour tends to fix (transfix might be a more apt word) the therapist. This may consist in his candid disagreement with some of the patient's strongly felt and long-voiced views, or in his flatly declining to try to feel 'sympathy'–such as one would be conventionally expected to feel–in response to behaviour which seems, at first glance, to express the most pitiable suffering but which the therapist is convinced primarily expresses sadism on the patient's part. Such courage to differ with the expected social role is what is needed from the therapist, in order to bring to a close the

symbiotic phase of relatedness which has served, earlier, a necessary and productive function. Through asserting his individuality here and at many later moments in the therapeutic interaction, the therapist fosters the patient's own development of more complete and durable ego-boundaries. At the same time he offers the patient the opportunity to identify with a parent-figure who dares to be an individual–dares to be so in the face of pressures which are at times great; pressures from the working group of which he is a part, and from his own reproachful super-ego. What I am describing here is, of course, to only a minor degree a consciously planned and controlled therapeutic 'technique'. It is rather a natural flow of events in the transference evolution, with which the therapist must have the spontaneity to go along.

Now let us see what happens in the relationship between a therapist and a patient who is at the other end of the scale: one who is severely and overtly fragmented in his functioning, and whose urgent need at the moment is not for further differentiation, but for integration. Incidentally, we are dealing here not with two discretely different 'types' of patient but, perhaps more accurately, with markedly different phases of personality development. We find that a single patient can show, over the course of time, each of these two extremes–on the one hand stereotypy with a need for differentiation, and on the other fragmentation with a need for integration.

In the instance of the severely and openly fragmented patient, we find that this fragmentation places severe stress upon the therapist, fostering a sense of fragmentation in him as well. The therapist not only finds that, as one fragment of the patient's personality unpredictably replaces another quite different fragment on the scene of the therapeutic session, he, the therapist, finds his own responsive feelings as suddenly switching from, say, fury to compassion, or sexual titillation to loathing, or what not. A patient who suddenly, while in the midst of delicately sensuous comments about the silken draperies in the room, switches to expressions of murderous feeling, or a patient who pauses in the midst of a savage paranoid castigating of the therapist to ask him, in a calm, friendly, matter of fact way, for a light for her cigarette, tends to make the therapist feel tossed between suddenly changing, intense affects within himself. And, worst of all, he sometimes

finds himself having strong and utterly contrasting feelings towards the patient simultaneously. He may, for example, find himself reacting to her as being, simultaneously, a murderous woman and an appealing little child. The therapist's capacity to endure such a barrage of fragmentation-fostering experiences, from both without and within, is essential in his helping the patient to become better integrated through identification with the therapist whose personal integration can survive this onslaught.

Wexler (1952) and Hoedemaker (1955) have stressed the therapeutic value, in other connexions, of the schizophrenic patient's identifying with the therapist. I find that this holds also with regard to the integration of the previously disparate areas of his personality. I have regularly found that my own achievement of an integrated view of the patient, towards whom I have previously been responding upon two or more quite distinct and conflictual levels, is a prelude to the patient's own improved integration. It seems that the therapist needs to integrate, for example, his view of the patient as a murderous woman, with his view of the patient as an appealing child, and must respond to the patient as a unitary person who possesses both these different personality-facets, before the patient can subjectively integrate these different, heretofore more or less dissociated areas into her conception of her self.

Processes in the patient's personality which exist in a dissociated state are maintained out of awareness, basically for the reason that the affects contained in them are so intense, so conflictual, and so opposed to those prevailing in the conscious ego. Early in the therapeutic relationship the therapist, even though able to discern in general terms the type or types of affects which are being expressed in the patient's dissociated behaviour or dissociated verbalizations, usually feels these dissociated personality components to be strange, alien, and bizarre. He does not yet find himself reacting to them with any fullness of personal response, for they are too much to one side of that interpersonal relationship which he shares with the more conscious areas of the patient's personality. But as the therapeutic relationship progresses and expands, this dissociated material gradually becomes turned towards the therapist, and he finds himself having, in response to it, feelings which grow

concomitantly extremely intense. His freedom to express such personal responses–whether they be in the nature of fury, contempt, tenderness, erotic feelings (these last being no more than frankly acknowledged by him, when the patient shows a need for such corroboration), is of inestimable value in helping to integrate the erstwhile dissociated components of the patient's personality.

Such integration has to take place first, or at any rate concomitantly, on an interpersonal level–namely, in the give-and-take of the therapeutic relationship–to the tune of intensely felt mutual expressions of affect, in order that the patient may become free from the dissociative compartmentalization, and become thus a more whole person. In this process, what was sensed by the therapist as alien and bizarre in the patient must come to be eventually 'taken personally' by the therapist. It must come to have the meaning of a complex of very personal communications before it can lose its alienness, its dissociated nature, for the patient as well.

Paradoxically, the experienced therapist can thus predict, on starting work with a patient, that the more queer, strange, alien, animal-like or otherwise not quite human the patient appears, the more deeply will the therapist's own most personal feelings eventually be plumbed in the course of successful therapy with the patient. He can predict that he himself will experience fury of an intensity he has experienced rarely if ever before within memory, fondness of a purity he has never felt perhaps since early childhood, compassion of a depth of which he had thought himself incapable. But he can predict, by the same token, that if the treatment is successful, he himself will emerge from it with a deepened regard for human beings and with an increased integration, in the phrase of Whitaker and Malone (1953), of his own 'multiple selves'.

To return to the kind of stress which he must endure along the way, we find that in some instances the patient's personality fragmentation is so deep that even his body image is fragmented, and his view of the world regressed to a level at which other persons are viewed not as complete physical beings but as separate anatomical parts. Klein (1946) and Scott (1955) have postulated that the very young infant presumably views the mother in this way. The therapist, in this phase of the therapy,

may find it so anxiety-provoking to find the patient expressing a conviction that his (the therapist's) head or hand, for example, is not his own, that he may resort to the somewhat relieving conviction that the patient is merely being hostile, rather than facing the anxiety-provoking fact that the patient is genuinely operating at so early a level of personality development that even the patient's image of his own body, and of the bodies of other persons including the therapist, is not yet fully formed and integrated.

Further, in the transference, the patient persistently relates to the therapist as being a parent who has many dissociated components of personality, with the result that the therapist, in the face of the patient's persistently and convincedly relating to him thus, tends naturally to function accordingly, to a degree not usual for him in his general relationships with people. M. B. Cohen (1952) has made the valuable point that we inevitably respond to any patient's transference with functioning which, to a degree, is complementary to that transference. In the kind of situation which I am describing, the therapist tends naturally, in response to the patient's special kind of transference, to dissociate rage (for instance) which, in other kinds of transference relationships with other patients, he might relatively easily admit into his own awareness. For example, to put it crudely but not inaccurately, if the patient reacts persistently and vigorously and long enough to the therapist as being a mother who has intense but dissociated murderousness, the therapist will in all probability come, one day, to find himself frightened at seeing how powerful are the murderous feelings which have grown up in him towards the patient.

Coleman (1956) and Coleman and Nelson (1957) have described a psychotherapeutic technique, which the former has employed with borderline patients, termed 'externalization of the toxic introject'. This technique consists in the therapist's deliberate impersonation of—conscious and calculated assumption of the role of—a traumatic parent, or other figure from the patient's early years, the long-standing introjection of whom comprised a 'toxic introject', the core of the borderline schizophrenic illness. The authors' psychodynamic formulations are of much interest, and highly relevant to what I have said above.

The great difference between Coleman and myself, however,

is that in my experience the therapist does not express, in such situations, affects which are merely a kind of play-acting, deliberately assumed and employed as a technical manœuvre indicated at the moment. Rather, in my experience, the affects are genuine, spontaneous, and at times almost overwhelmingly intense. This differing experience can presumably be accounted for, in part, by the circumstance that whereas Coleman was dealing with borderline cases, I have been dealing with frankly schizophrenic patients. With the latter kind of patient, because his affects are so extremely intense and his ego-boundaries so very incomplete, his therapist's own feelings become more deeply and fully involved. I have discussed this subject at greater length in chapter 6 above, and in *The Nonhuman Environment.*

Both patient and therapist, in working towards the integration of the former's disparate personality components (and, as Whitaker and Malone, 1953, have pointed out, this is a mutual process, involving the therapist's own personality integration), have an inescapable resistance to overcome. Increasing integration involves, for both of them, loss. The integration of heretofore separate personality fragments inevitably alters them—they lose, in the process, their pure-culture, pristine quality upon becoming adulterated, as it were, with other areas of the personality. And correspondingly one's own responsive reactions to them lose in purity.

I think for example of a woman who was, at the beginning of our work some years ago, extremely unintegrated in her personality functioning. She behaved from one session to the next, and often from one moment to the next, like a whole galaxy of utterly different persons. She has become, over the years, partly by dint of much hard work on the part of both of us, much better integrated. Life for her now involves more continuity, less anxiety, more genuine happiness; and I feel vastly more comfortable in the hours with her. But we have lost much, too. Just how much, I tend to forget until I look back through my old notes concerning our work. The beer-hall bouncer I used to know is no more. The captured American pilot, held prisoner by the Germans but striding proudly several paces ahead of the despised prison-camp guard, is no more. The frightening lioness has gone from her den. The incarnation of paranoid hatred, spewing hostility at the whole world, has mellowed into someone unrecognizably

different. The endearing little girl can no longer hide the adult woman who is now part of her. The fresh-faced girl of sixteen or so has come and gone—one sees her to a degree, of course, but alloyed now with other qualities. No more is there someone who tells me that I am a murderous woman who has killed my husband and am now about to kill my patient also. No longer is there someone, so far as I know, who thinks that I am a machine, sent to her room to destroy her. No one now perceives me as being, not a living person, but a pile of corpses, and so on. It is as though a whole gallery of portraits, some of them beautiful and some of them horrible, but all of them free from diluting imperfections, have been sacrificed in the formation of the single, far more complex and many-sided portrait, the relatively well-integrated person who now exists.

What I have been saying ties in with Rosenfeld's (1950) comment that schizophrenic confusion involves an anxiety lest the destructive impulses and objects destroy the libidinal impulses and objects, and my (chapter 1 above) comment that the schizophrenic is equally afraid that the hostile side of his ambivalent feelings will be destroyed by the positive (libidinal) side.

Of interest in this connexion is a comment by Hartmann, Kris and Loewenstein (1949) regarding the normal infant:

'We start from the assumption of the existence of an undifferentiated phase of psychic structure. During this phase manifestations of both libido and aggression are frequently indistinguishable or difficult to distinguish.' Presumably the schizophrenic adult's fear lest he lose either his loving or his hateful feelings (or both) is based in *part* upon the threat of regression to such an undifferentiated phase.

The above discussion is a result of my discovering that, here again, the schizophrenic's—and the therapist's—anxiety is well founded. Something is indeed destroyed, and must be destroyed, in the process of mutual integration which takes place in the therapy. In the instance of the woman of whom I wrote above, for example, I can no longer love her and be charmed by her in quite the way I formerly could, *nor* can I hate, loathe, and fear her with quite the intensity and 'purity' which used to be not only possible, but necessary, in the progress of the therapeutic relationship. My capacity to love, hate, and so forth, in those wave-lengths is not really destroyed, but it may be a long time,

if ever, before I find in my life occasions which call forth such emotions. In so far as the therapy has been successful, it has in effect, for all practical purposes, destroyed them. And though she on occasion tries to recapture, for example, her old venom, it comes out only weakly now, like a nostalgic echo. (When Wexler (1951) wrote, '. . . I have been through two years of hell-fire and heaven with a schizophrenic patient . . .', he was feeling, I surmise, a sense not only of triumph but also of nostalgia.)

What we have gained more than makes up, of course, for such losses; otherwise her integration could not have progressed so far. She now has feelings—in the realm of both healthy anger and of deep and mature fondness—and complexities of feeling of which she was clearly incapable at the outset of our work, and the relationship between us has likewise become emotionally enriched. I have discussed at some length the losses which were involved in this over-all gain, because I have seen, not only in my own work but in that of fellow-therapists, how often the patient's and therapist's mutual, unconscious *denial* of this element of loss causes an undue prolongation of the disintegrated state.

As regards the patient's advancing differentiation too, there is a similarly great resistance in both participants. Diligently though both are working towards the delineation of ego-boundaries in the relationship, so that the patient may become subjectively differentiated as a truly individual human being, both he and the therapist must endure a genuine and deep sense of loss in the process of this accomplishment. Both must relinquish, as I have described in chapter 7, the sense of oceanic contentment, felt omnipotence, and mother-infant adoration which are ingredients of the symbiotic relatedness.[4]

[4] My interest in the subject of differentiation has been fostered, in part, by stimulating remarks which I have heard in recent years from Drs Robert A. Cohen, David M. Rioch, and Otto A. Will.