As I stated in my review (1965b) of Jacobson's book, "I believe that the more successfully the infant and young child internalizes, as the foundation of his personal identity, a symbiotic relationship with a predominantly loving mother, the more accessible is his symbiotic level of existence, in all its infinite richness, to the more structured aspects of identity which develop—which develop not primarily as imposed restraints upon him, but as structures that facilitate the release of his energies and capacities in creative relatedness with the outer world." Such a symbiosis-based identity serves as one's most sensitive and reliable organ for perceiving the world, not merely by mirroring a world set at some distance, but through processes of introjection and projection, literally sampling, literally mingling with—in manageable increments—the world through which, moment by changing moment, one moves.

We come to see, now, that the two seemingly contradictory uses of the word "identity"—as meaning on the one hand unique set-apartness, and on the other hand sameness, unity—are not really contradictory; for identity embraces, at once, one's unique self and the world with which that self is at one.

# 5

# *The "Dedicated Physician" in the Field of Psychotherapy and Psychoanalysis*

Psychiatric patients, above all schizophrenic patients, cause one to doubt one's capacity to love, and to feel that one's devotion is meaningless or, worse, malevolent. For example, when I used to see a hebephrenic woman, with whom I had been working for ten years, walking about on the hospital grounds, appearing vague, disheveled, bleakly unloved, I felt her to be a kind of living, ambulatory monument to my cruelty and neglect. Even though I had not forgotten that I had been subjected to something like 2,000 hours of her reviling me, ignoring me, sexually tantalizing me, making heart rendingly unanswerable appeals to me either mutely or in largely undecipherable words, and so on, I still winced at the sight of her. It was as though the Methodist hell of my boyhood yawned widely for my thus-proven un-Christlike soul.

A year or two previously, on one of the rare days when she had her wits sufficiently about her to be considered able to come with me to my office, about 100 feet away, she stood in confused helplessness while an ostensibly kind, loving, gentle female aide,

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who (as I later came to realize) busily infantilized all the patients, put shoes on this woman's feet. I felt remorse because I did not feel at all like doing so—because I was feeling, at that moment, nothing toward the patient except hatred, impatience, and contempt.

My papers have chronicled my findings, to my mingled relief and self-deflation, how able schizophrenic patients are not merely to endure, but to turn to therapeutic benefit, one's expressions of deepeningly intense feelings of all kinds. But the events of my final year at Chestnut Lodge showed that I had, nonetheless, underestimated to the last these patients' strengths. I gave notice, one year in advance, of my intention to leave the Lodge; such notice was required by my contract which in turn, of course, was based on clinical and staffing necessities. As I regarded it feasible to go on working with no more than two of my six patients after I left there, I was now faced with the immensely difficult matter of which two, among six patients, each of whom I had been working with intensively for years, I would go on seeing. With one of these patients I had worked for nearly six years; with four, between ten and eleven years each; and with one, for thirteen and a half.

My ambivalence toward each of these individuals, like his or her own toward me, of course, knew no bounds. I wanted utterly to be rid of the whole lot of them, yet felt almost unbearably anguished at the prospect of losing any one of them. A passage from my last staff presentation at the Lodge, just before I left, expresses something of what I had come to learn of the strength each of these persons possessed:

> The one biggest lesson . . . I have learned in working with schizophrenic patients in my last year here has been to see how very tough they are. . . . I can say that I have, in this last year, burdened or battered, or whatever, each of these six patients with all the sarcasm, harshness, contempt, and just general resentment and reviling that I'm capable of and they've all survived it fine, see, just fine, and I have felt that I have just barely been operating in their league—just barely been qualifying to be in the major leagues. When I start this with Edna she is soon on the offensive again; she can take all I've got and she can go on more.



> Another way that I conceptualize it is, the work is so goddamned difficult that we cannot do it if we deny ourselves certain parts of our armamentarium. We can't do it with one hand tied behind our back. So this has been something memorable to me; this I'm going to keep using with patients. I am.

My experiences with colleagues over all these same years, as a supervisor or a consultant in their work with their schizophrenic patients, have shown me, similarly, with what toughness, tenacity, and sadistic virtuosity their patients tend to coerce these therapists into the ever-alluring role of the dedicated physician treating the supposedly weaker patient. Typically, to the extent that one feels bound by the traditional physician's role, one feels wholly responsible for the course of the patient's illness, and feels it impermissible to experience any feelings toward the patient except for kindly, attentive, long-suffering, and helpful dedication. The psychiatric resident, in particular, relatively fresh from the dedicated-physician atmosphere of the medical school and general internship, is often genuinely unaware of feeling any hatred or even anger toward the patient who is daily ignoring or intimidating or castigating him, and unaware of how his very dedication, above all, makes him the prey of the patient's sadism. It has been many years since a young schizophrenic man revealed to me how much sadistic pleasure he derived from seeing a succession of dedicated therapists battering their heads bloody against the wall of his indifference, and I have never forgotten that.

In general, if the patient's illness is causing more suffering to the therapist than to the patient, something is wrong. But it is not at all easy, technically, to become more comfortable than the patient. With many schizophrenic patients, one tends to feel like a butterfly, pinned squirmingly in their live-butterfly collection, without any reliable way of drawing blood from the invulnerable patient. It is our omnipotent self-expectations that, more than anything else, pinion us and tend, as well, to stalemate or sever the therapeutic relationship. The obnoxiously behaving paranoid patient cannot help but wonder what ulterior motives make us so concerned to *keep him in therapy*; instead of our becoming aware of our

angrily wanting to be rid of him, we act out our repressed desires to reject him, by manifesting an omnipotence-based, devouring, vampirelike devotion which understandably frightens him away from treatment. And the suicidal patient, who finds us so unable to be aware of the murderous feelings he fosters in us through his guilt- and anxiety-producing threats of suicide, feels increasingly constricted, perhaps indeed to the point of suicide, by the therapist who, in reaction formation against his intensifying, unconscious wishes to kill the patient, hovers increasingly "protectively" about the latter, for whom he feels an omnipotence-based physicianly concern. Hence it is, paradoxically, the very physician most anxiously concerned to *keep the patient alive* who tends most vigorously, at an unconscious level, to drive him to what has come to seem the only autonomous act left to him—namely, suicide.

The therapist's functioning in the spirit of dedication, which is the norm among physicians in other branches of medicine, represents here, in the practice of psychotherapy and psychoanalysis, an unconscious defense against his seeing clearly many crucial aspects of both the patient and himself.

Among the aspects of the patient to which such dedication tends to blind him is the already-mentioned sadism. He does not see how much sadistic gratification the patient is deriving from his therapist's anguished, tormented, futile dedication. He does not realize that, as I overheard one chronically schizophrenic man confide to his therapist, "The pleasure I get in torturing you is the main reason I go on staying in this hospital." I had heard this therapist describe how, for many months, he had never known, when he went into this man's room on the disturbed ward, whether to expect a blow or a kiss from the patient.

Further, the dedicated therapist does not see how much ambivalence the patient has about change, even change for the "better." He does not see that the patient has reached his present equilibrium only after years of thought and effort and the exercise of the best judgment of which he is capable. To the patient, change tends to mean a return to an intolerable pre-equilibrium state, and the imposition upon him of the therapist's values, the therapist's personality, with no autonomy, no individuality, for him. He resents the therapist's presumption in assuming that the patient is pitiably eager to be rescued, and in assuming, equally humiliatingly, that the intended help is all unidirectional, from therapist to patient.

A dozen years ago I reached the conviction that it is folly to set out to rescue the patient from the dragon of schizophrenia: the patient is both the maiden in the dragon's grip, and the dragon itself. The dragon is the patient's resistance to becoming "sane"—resistance which shows itself as a tenacious and savage hostility to the therapist's efforts.

The heart of this resistance springs from the fact that the patient's own raison d'être, since early childhood, has been as a therapist, originally to the parent whose unwhole integration he, the child, was called upon to complement, in a pathological and unnaturally prolonged symbiosis. He was given over to this therapeutic dedication, as a small child, for the most altruistic of reasons—he lived in order to make mother (or father) whole—as well as for reasons of his own self-interest, so that he would have a whole parent with whom to identify, for the sake of his own maturation. But he failed in this therapeutic dedication and, more hurtfully still, the fact of this dedication was not even recognized by the parent, who incessantly hurt, disparaged, and rejected him. Thus now, as an adult schizophrenic patient in treatment, he takes vengeance upon this rival, "official" therapist of his, and causes his therapist to feel as anguished, futile, and worthless or malevolent an intended healer as he, the patient, had been given to feel by his mother or father. Only insofar as the therapist becomes able to see, and respond to, the patient's genuinely therapeutic striving toward him, and earlier toward the parents, will the patient be himself receptive to therapy. Among my feelings during my final year at Chestnut Lodge was, prominently, grief at various of my patients' having refused to identify sufficiently with my healthier aspects and, by the same token, grief at my own having failed to help them do so. I surmise that such grief is of a piece with the patient's own repressed grief, stemming from early childhood, at being unable to save the sick parent through encouraging the latter to identify with

the healthier aspects of the patient as a growing child.

We therapists tend to feel frightened away from seeing how concerned our patients are to help us, partly for the reason that the transference distortions, in which this therapeutic striving of theirs is couched, are very great. That is, our patient tends to see us as being not merely somewhat depressed today, but as being his deeply, suicidally despondent father; or he perceives us as being not merely somewhat scatterbrained today, but as being his insane, hopelessly fragmented mother.

Patients' specific therapeutic aims, and their individual techniques in pursuing those aims, are manifold. Various patients of mine, for example, have rescued me from periods of withdrawal and depression by presenting themselves as being in such urgent need of rescue that I have felt it necessary to bestir myself, come out of myself, and thus cast off the chains of my depression in order to save them. Others, by presenting themselves as being infuriatingly, outrageously undisciplined, have eventually "made a man of" me—have made me, through impelling me into being a stern disciplinarian, into the kind of man they had been unable to make their wishy-washy father into.

Their therapeutic techniques are outwardly so brutal that the therapeutic intent is seen only in the result. One apathetic, dilapidated hebephrenic patient of mine received considerable therapeutic benefit from a fellow patient, newly come to the ward but, like him, a veteran of several years in mental hospitals. This fellow patient repeatedly, throughout the day, gave my patient a vigorous and unexpected kick in the behind. From what I could see, this was the first time in years another patient had shown any real interest in him, and my patient emerged appreciably from his state of apathy and hopelessness as a result.

As for the many crucial aspects of himself, in relation to the patient, against which the therapist is unconsciously defending himself with his physicianly dedication, I have already touched upon some of these. He is unaware of how much he is enjoying his tormenting the patient with this dedication, of which the patient, who feels himself to be so hateful and incapable of giving anything worthwhile to anyone, feels so unworthy. He is unaware, similarly, of how much scorn his own "dedication" is expressing. I asked a female colleague, who was describing her work, a very actively dedicated and ostensibly maternally loving work, with a deeply regressed woman, how much ego she felt the patient to have. The therapist replied, as though this were obvious, "None." Such unconscious scorn for the patient—for the patient's own strength and for his ability to reach out, himself, for help from the therapist, without the therapist's having constantly to keep pushing the help at him—seems to me to betray much self-contempt on the part of the therapist. If the therapist is convinced that he himself is a worthwhile person, with something useful to give—with something, that is, which this fellow human being, the patient, can be relied upon to discern and to admire and want—he will not need to try, anxiously and incessantly, to persuade the patient to accept his help.



Further, the "dedicated" therapist, who feels under such intense pressure to cure the patient, goes on oblivious of his placing, in his dedication, equally great pressure upon the patient. Here I can offer a vignette from my own work. A paranoid schizophrenic woman whom I have been treating for years has come, in recent months, to spend many sessions wet-eyed, describing in verbose detail her life experience, current and past, in terms implying that there is an ocean of grief in her, but never with any frank outpouring of tears. Finally, at the end of one such session, I confided to her, with mixed feelings of guilt and exasperation, that at the end of such an hour as this, as had happened so many times before, "You always make me feel remiss in not having said or done something that would enable you to weep." To my surprise, she instantly responded with something which had evidently been on her mind, similarly, for many sessions—"and *you* always make *me* feel remiss for not weeping."

The supervision of other therapists gives one a chance to see these things more objectively and, of course, with less harsh narcissistic injury to oneself. Specifically, one can clearly feel how sadistic are the demands upon himself, week after week, of the so-

dedicated therapist who is so agonizedly eager to cure his patient. One such therapist, chronically depressed and long-suffering about the work with his patient but chronically "dedicated" to the latter, would tell me, week after week, of his patient's asking him, "What do I do? What's the right thing to do?" The therapist himself was passing along to me much this same kind of draining and unanswerable demand, by implicitly asking me, throughout each supervisory session, "Doc, what do I do to relieve my suffering at the hands of this patient who is crucifying me?"

Our "dedicated-physician" way of relating to the patient serves not only to act out our sadism toward him, but also to express our unconscious determination to maintain the status quo—to preserve the patient's present, immature level of ego functioning in order to ensure the inflow of deniedly cherished supplies from him. Thus, the loosening of the stalemate requires that the therapist become aware not only of his sadism and other negative feelings toward the patient, but also of his cherishing what the latter has been providing him.

In other words, an intensely pressuring, dedicated therapeutic zeal denotes an unconscious determination, on the part of the therapist, to protect and preserve, for reasons of his own psychic economy, the patient's present level of psychotic or neurotic ego functioning. This determination arises from the various narcissistic and infantile gratifications the therapist is receiving from the patient, who represents at one level a transference-mother who is feeding him, as well as from the fact that the patient's illness serves to shield the therapist from seeing clearly his own illness.

So, unconsciously, the therapist is bent upon maintaining the patient in an infantilized state, and is opposing that very individuation and maturation to which, at a conscious level, he is genuinely dedicated. As I have already indicated, I, for one, tend dedicatedly to remain immersed in a rescue effort toward the "fragile" patient, in order to avoid seeing him or her as being stronger, or potentially stronger, than myself. For example, one hebephrenic woman, from whose incredibly low levels of ego functioning I derived much fascinating data about the schizophrenic patient's subjectively "prehuman" identity (data included in my monograph on the nonhuman environment [1960]), finally told me, in vigorous protest, "I can't stay down forever!" This woman would evidence, from time to time over the years of our work, remarkable forward surges in her ego functioning, and unfailingly I would find that my rejoicing in this development was outweighed by an upsurge of my feeling inadequate. I had been feeling despair at how grievously ill she was; but now I would find her manifesting an appearance of blooming physical health which made me feel old and jaded. I would be reminded, ruefully, too, that she was physically taller than I. In the same process, she would reveal a kind of effortless savoir faire, in matters both interpersonal and cultural, traceable to an upbringing far richer in social and cultural "advantages" than my own. In short, I would feel her to be an all-around hopelessly larger person than myself. Then, as if quickly detecting that I still couldn't take it, she would soon be, again, her deeply fragmented, "hopelessly ill" hebephrenic self, and I was once more in my comfortable role of the long-suffering Christ trying to heal the wounded bird.



Even more embarrassingly, I found my feelings toward another long-schizophrenic woman oscillating, often session by session for months on end, from my viewing her as a hopelessly confused mental patient who, clearly incurably ill, would undoubtedly be spending the rest of her life in psychiatric hospitals, to my viewing her as a predominantly well, wonderfully warm, intelligent, and witty woman for whom I felt greatly tempted to give up everyone and everything else in my life, but who, I had anguishedly to realize, recurrently, could never practicably be mine. At this point, incidentally, it should be abundantly clear that, among the needs for which the "dedicated" therapist is obtaining gratification are his masochistic needs.

If one examines more deeply the psychodynamics of the dedicated-physician therapist who is unconsciously devoted to preserving the status quo, one finds that he holds, at an unconscious level, split images—one an idealized image and the other a diabolized image—of himself and of the patient as well. One also finds that he is dedicated, unconsciously but tenaciously, to preserv-

ing these split images and preventing their coalescence, with the leaven of reality, into realistic images of himself and of the patient as two fellow human beings, each possessing both strengths and limitations upon his strengths, each capable of both hating and loving.

As a function of his unconscious effort to preserve these split images, the therapist represses the ingredients of his diabolized self-image—his hatred, his rejectingness, his subjectively nonhuman unfeelingness, and so on—and projects these upon the patient. At the same time that he is placing intense, though unwitting demands upon the patient to emerge in such a healthy way as will enable the therapist to realize his idealized self-image as an all-loving, omnipotent healer, he is unconsciously holding at a safe distance, or driving progressively deeper into autism, this patient who personifies the diabolized, unacceptable, and therefore vigorously projected aspects of his own self-image. Thus the therapist's dedication becomes, as seen from this vantage point, an anxious, deeply ambivalent effort to both make contact with and keep safely at a distance the projected components of his *self*.

To describe this a bit further, we see how well it serves the therapist's unconscious rejectingness for the patient to become progressively withdrawn. Consciously, he is dedicated to making contact with the patient and helping him to join him in the "real world"; but unconsciously he wants to be rid of the disappointing, frightening, and otherwise unsatisfactory patient—the patient who by any standards is so, and all the more by reason of the therapist's unconscious image of him as presently diabolical, no matter how much the therapist clings also to the unconscious hope that the patient may one day fit an ideal image. In still other terms, the therapist is trying consciously to help the withdrawn patient to materialize, while unconsciously he wants to make the latter disappear. In proportion as the patient becomes able to evidence love, the therapist's projected image of himself as diabolical comes home to roost, and he tends to perceive himself as subhumanly bad, malevolently obstructing the full liberation of the patient's supposedly suprahumanly good self. What makes this so formidable a



difficulty in therapy is not so much that the therapist is unadulteratedly neurotic, but rather that the chronically schizophrenic patient contributes, to the maintenance of these processes of splitting, a degree of intensity and tenacity of which the therapist's own stake in the matter is a relatively small sample. But it is the therapist's own dawning recognition of his "countertransference"—his own contribution to these stalemating processes—that provides the best handle for his effecting a change in the therapeutic relationship; that is why I dwell here upon the therapist's contribution to the difficulties.

We tend, thus, to make the patient feel both idealized and diabolized by us, with a hopelessly unbridgeable gulf between these two so-different creatures we are calling upon him to be, toward us. At the same time that we are unwittingly calling upon him to fulfill our diabolized image of him, we are unconsciously looking to him to provide our life with its central meaning, to give us a raison d'être, to make real our idealized self-image. I want to emphasize that it is no pernicious thing *consciously* to regard the patient as supremely important and meaningful to oneself. For us consciously so to relate to him cannot but enhance his self-esteem and help him to become whole. The pernicious thing is that we repress both our idealized image and our diabolized image of him, hide both from ourself, and at the same time act out both these toward him by inappropriately employing, in psychotherapy and psychoanalysis, the traditional dedicated-physician-treating-his-patient approach which, however conventionally accepted in the practice of medicine generally, congeals and reinforces the wall between patient and doctor when we employ it in this field.

Paradoxically, the withdrawn patient is likely to be identifying with the very therapist who is consciously devoted to a diligent and even desperate attempt to help him emerge from the withdrawal, but much of whose feelings are in actuality withdrawn from his conscious attitudes toward the patient. That is, the patient, in seeking the isolation of the seclusion room, may well be identifying with those increments of the therapist which are secluded off from access to the therapist's conscious ways of viewing, and relating to, the

patient. This is one variety of what I have termed, in an earlier paper (Searles, 1963b), the patient's delusional identification with his therapist; in general, these are instances in which the most tenacious, treatment-resistant aspects of the patient's craziness are found to be based upon his exaggerated and distorted identifications with real but unconscious aspects of the therapist's own personality and ways of functioning in the treatment relationship.

In discussing, now, the phenomena marking the resolution of these dedicated-physician stalemates—phenomena of which I have already given some hint—I have in mind the form this resolution takes in one's work with the schizophrenic patient on the one hand, and with the depressed patient on the other hand; but there are many patients, of course, who show prominently both these varieties of psychopathology.

In any case, as the therapist becomes aware of the whole gamut of his feelings toward the patient, he comes to see that the latter is a real and separate person, afflicted with an illness which is also a part of genuinely outer reality for the therapist, rather than its being the product of the therapist's heretofore-repressed, subjectively omnipotent hatred and infantile demands.

As we become free from our previous, compulsive "dedication" and able now to view the patient and our relationship with him with this new objectivity, we no longer assume a wholehearted, dedicated interest on our part as a *given* in the situation, and can notice fluctuations in our interest toward him, fluctuations often fostered by him and of much transference significance. For example, I have seen that, with various patients of mine, just as we get to working closely and most constructively together, the patient will do something (such as making a last-minute, inconsiderate and impersonal cancellation of a session) which cools my interest in him. This action reveals to me his fear of closeness with me, his fear of my strong and sustained and deepening interest in him, which I would not have detected had I gone on holding myself totally responsible for maintaining an unflagging interest in helping him—had I gone on feeling guilty whenever I found myself disinterested in him and not caring whether or not he might elect to continue with our work. This is but an example of how, in analytic terms, a therapist's physicianly, compulsive "dedication" interferes with the kind of free-floating objectivity which is so necessary an ingredient of the analyst's effective functioning.

As our previous, compulsive dedication loosens its grip upon us, we become aware, lo and behold, of a keen aesthetic appreciation of that very illness, in the patient, which heretofore we have felt so desperately and guiltily responsible for curing. Several years ago, I found myself having to face the fact that I seemed to find the schizophrenic aspects much more fascinating than the more conventional and healthier aspects of my patients' functioning. At first, I felt deeply troubled at this discovery, for I felt it must mean that I am dedicated more to the causation and preservation of severe and exotic illness than to the fostering of health in my patients. But then I began to see that this preference, on my part, was not so unnatural after all. Keeping in mind the point I made earlier, that the schizophrenic patient is not only the maiden in the dragon's grip but the dragon also, let me ask you which of these you find more fascinating—the relatively pallid and conventional lady, or the exotic and colorful dragon?[1]

I have been deeply reassured to find, as time has gone on, that this very aesthetic appreciation is a form of scientific interest which, in contrast to my earlier, so anguished therapeutic dedication, enables me to be of maximal real use to the patient. For example, I used to feel, for years, desperately and urgently concerned to relieve the indescribably severe confusion of one of my chronically schizophrenic patients, and it was with guilt bordering on self-loathing that I began to realize that I was actually fascinated by the vivid, intricate, so-unconventional nature of her confusion itself. At

[1]A mere second, or even first, glance at Uccello's painting (p. 84), will show that, in this particular artist's rendition of the myth of Saint George and the dragon, there is a tongue-in-cheek quality, for the dragon is the lady's pet on a leash. I use the painting here despite, rather than because of, this aspect of it. I by no means regard schizophrenia as being, in any overall sense, within the patient's conscious control like a pet on a leash. Vivid paintings portraying Saint George and the dragon and the lady are less easy to find than I had assumed.

Paolo Uccello. *St. George and the Dragon.*
(Reproduced by courtesy of the Trustees, The National Gallery, London.)



first my interest in this felt unclean, perverse, unworthy of any physician; but gradually I came to feel that I was facing a genuine work of creative art which was after all, as I now clearly see, the product of the highest forms of the patient's intelligence and creative originality. As for her, she showed every evidence of finding much more useful my appreciative, unanxious, and unguilty studying of her confused verbalizations than she had found my desperate attempts to somehow shut them off.

Along with such aesthetic-scientific interest one comes to feel, as one becomes freer from omnipotent guilt about the patient and his illness, companion gratifications in the realm of humor and playfulness—all necessary ingredients of the phase of the mutually enjoyable therapeutic symbiosis I have described in a number of papers. Time after time I have found that the patient benefits most from our sharing of humorous, playful moments together. When I can leave off my deadly serious dedication, and be amused at the patient's craziness, he can come to laugh with warm and loving amusement at the delightfully crazy foibles of his mother, whom he had been desperately dedicated, heretofore, to curing, at an introjected level, in his own so-tragic craziness. When one is working in this new spirit with the patient, one is very close to him, openly showing how much one likes and enjoys being with him. His formerly maddening symptoms are now only part of the background music in an atmosphere of contentment.

As the therapist becomes aware of how much gratification the illness is providing to himself as well as to the patient, he becomes free of his infantile-omnipotence-based, guilty feeling of *having to cure* the patient. The patient genuinely is faced now, not simply at one crucial juncture but ongoingly, session after session, with the choice as to whether he himself wishes to cling to the gratifications of remaining ill, or whether he wishes to accept the therapist's *also*-offered assistance in becoming a healthy adult. He now becomes able to feel, as one patient told his therapist:

> It's like I see a more distinct me inside of me, and I can see a great future, and that I have promise. . . . It used to be like my mother and father and I were all lumped together, and it

was sick. If they want to stay sick and screwed up, it's their business and their choice; but it's not mine. I feel like I can get away from their sickness, and I damned well don't have to stay in it.

In concluding, I want to mention briefly three points. First, it seems to be impossible—and perhaps it would be untherapeutic, were it possible—for a therapist to have, at the beginning of his work with any one patient, and to maintain throughout the treatment, a realistic as opposed to an omnipotence-based feeling of dedication. It would be unclinical to postulate that there is some one most therapeutic attitude, as regards dedication, which the therapist should have at the beginning of the therapy, and maintain throughout it, beyond his dedicating himself as fully as possible to becoming aware of whatever thoughts and feelings are being called forth in the treatment process, in himself as well as in the patient. It seems inescapable that we shall go through torments of feeling omnipotently responsible for each of our patients, that we shall repress our sadism and project it upon the patient, shall come to develop split images of ourself and of the patient, and so on as I have been detailing, and it may well be that our becoming thus enmeshed, for a time, in the patient's illness is necessary to the therapeutic process. But I suggest that the considerations discussed here will facilitate our going through this evolution and emerging to a more realistic experience of ourself in relation to the patient. I suggest, in other words, that these considerations will help us to avert, or at least to shorten, such covertly sadomasochistic stalemates as are familiar clinical experiences to all of us.

Second, we see that the kind of therapist devotion characteristic of such stalemated situations is a genuinely "selfless" devotion, but selfless in a sense that is, in the long run, precisely antitherapeutic. That is, so many of the therapist's own unconscious ingredients are being projected onto the patient that he is in a real sense selflessly submerged in the patient's narcissism. In this sense, the therapist is deriving the unconscious gratification of functioning without the responsibility for having a self and thus, paradoxically, in his "selflessly dedicated" functioning, is burdening the patient with a total



responsibility for the whole relationship. Such "devotion," which temporarily supports the patient's narcissistic world-self, inevitably must be revealed, one day, as a lie. This disillusioning discovery, now, that the therapist after all is a separate person with a self of his own and self-interest of his own, after the patient has been led for so long to assume otherwise, will repeat, for the patient, his bitter childhood experience that, as one schizophrenic woman put it, "People are only interested in themselves." And, as a borderline schizophrenic man phrased it, "Kidding your children for 20 years that you love them and want them—this is what I'm bitter about, I guess; mother has *pretended* that she put me first, and it's just been her little game. It's not been true—she's more interested in herself, in her neurosis."

The paranoid individual is especially prone to assuming that if the therapist proves not to be wholeheartedly devoted to his (the patient's) welfare, then the therapist must be bent upon sabotaging and destroying him. This seems referable to the patient's experiences as a child, in which the parents maintained a "wholeheartedly devoted" demeanor toward him, in a reaction formation against their largely unconscious, more sinister feelings toward him—their hostility toward him, their wishes to be free of him. Hence he will remain suspicious, and with good reason, if we endeavor to submerge, from the beginning of his treatment, our self-interest in his "welfare."

Third, in earlier papers (Searles, 1965a) I have described the therapeutic symbiosis, which implies a degree of selflessness on the part of therapist as well as patient, as marking the most essential aspect of the treatment. But this stands in the most direct contrast to the kind of "dedicated-physician selflessness" this paper is calling into question. Where the latter is a defense against hatred and other "negative" emotions, this former kind of merging between patient and therapist can occur only after all emotions, of whatever variety, in either participant, have become sufficiently unthreatening so that these need no longer be defended against by the maintenance of a "self," a structure which, in light of the processes at work in this stage of the treatment evolution, could serve only as

a hindrance to the therapeutic processes, which are streaming toward new and deeper patterns of individuation for both patient and therapist, patterns at this point unpredictable and therefore all the more exciting and fulfilling.

# 6

# Paranoid Processes among Members of the Therapeutic Team

## The Subjectively Experienced Milieu

In the study of the schizophrenic quadruplets at the National Institute of Mental Health (NIMH) a few years ago I had a relatively small role, serving as supervisor throughout the individual therapy of one of the so-called Genain quads, and intermittently in the same capacity with a second member of the foursome. Tangential though my role was as a consultant with these limited functions, I shall never forget the awe with which this fantastically complex project was regarded, not only by myself but also by, as far as I could see, everyone else connected with it. The project seemed not so much to be composed of, but to be chronically devouring, four individual therapists and their several supervisors over the years, several administrators, innumerable social workers, nurses, and aides, and a galaxy of diverse scientists such as psychologists, sociologists, geneticists, and so on. At the nucleus of this chaotic mass, which was not divided into any such neat categories as I have enumerated

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