

THE EFFORT TO DRIVE THE OTHER PERSON CRAZY—AN
ELEMENT IN THE AETIOLOGY AND PSYCHOTHERAPY
OF SCHIZOPHRENIA*

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Among all the factors in the aetiology of schizophrenia, factors which are undoubtedly complex and, further, considerably variable from one case to another, there appears to be one specific ingredient which can often—and even, I believe, regularly—be found to be operative. My clinical experience has indicated that the individual becomes schizophrenic partly by reason of a long-continued effort, a largely or wholly unconscious effort, on the part of some person or persons highly important in his upbringing, to drive him crazy.

I well know that it would be inane to reduce the complex aetiology of schizophrenia to a simple formula stating that an individual becomes schizophrenic because some other individual drives him crazy. Such a formula would not do justice to the individual's own psychological activity in the situation, to the complexity of that particular interpersonal relationship, to the complex group-processes of the family situation, or to the larger socio-dynamic processes in which the family plays but a part—often a part in which the family as a whole is helpless to deal with large and tragic circumstances quite beyond any family's capacity to control or avert.

Previous literature

The only writings about this subject which I have found in the professional literature are statements by Arieti (1955), and by that group of researchers at the Mayo Foundation which is headed by Johnson (Beckett *et al.*, 1956; and Johnson, Giffin, Watson & Beckett, 1956),

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and these statements have done little more than touch upon the subject, without exploring it in detail.

Arieti describes what he terms 'acted-out' or 'externalized' psychoses, explaining that: '... These persons often create situations which will precipitate or engender psychoses in other people, whereas they themselves remain immune from overt symptoms.'

Johnson and her co-workers, reporting upon the concomitant psychotherapy of schizophrenic patients and the members of these patients' families, emphasize that this experience confirmed the authors' initial impression that '... in some cases parental expression of hostility through a child might both determine psychosis in the child and protect the parent from psychosis' (Beckett *et al.* 1956). In many instances they found a history of psychological assault by the parent(s) upon the child, assault of a type which was specifically reflected in the patient's earliest delusions. It is of special interest here that among the various types of assault they describe were '... threats that insanity may develop in the patient'.

Hill (1955), while nowhere formulating the particular concept which I am describing in this paper, presents a picture of a symbiotic patient-parent relationship which constitutes a conceptual background into which my concept fits, I believe, precisely. He says that the mother (or, in occasional instances, the father): '... Makes the conditions for [the child's] security in living those which meet her own defensive and aggressive requirements to avoid psychosis.' '... One meaning of the futility of the dependence-independence struggle of the schizophrenic... is his belief, based upon his

observations, that, if he should improve and become well in the normal sense, his mother would become psychotic. . . .'

Bowen (1956), as a result of concomitant psychotherapy of schizophrenic patients and their families, has reached conclusions similar to those of Hill. Reichard & Tillman (1950), Lidz & Lidz (1952) and Limentani (1956) are among the other writers whose discussions of symbiotic relatedness are relevant to my paper.

My theoretical formulations will be presented, with such brief samples of clinical documentation as space will allow, in the following categories: (A) *modes* of one's driving the other person crazy, (B) *motives* behind the effort to drive the other person crazy, and (C) this mode of interaction in the *patient-therapist relationship*.

A. MODES OF DRIVING THE OTHER PERSON CRAZY

In trying to delineate the modes or techniques which are employed in one person's effort to drive another person crazy—or, in our professional terminology, schizophrenic—I cannot overemphasize my conviction that the striving goes on at a predominantly *unconscious* level, and my conviction that this is but one ingredient in a complex pathogenic relatedness which is well beyond the capacity of either one, or both, of the participants to control fully.

In general one can say, I think, that *the initiating of any kind of interpersonal interaction which tends to foster emotional conflict in the other person—which tends to activate various areas of his personality in opposition to one another—tends to drive him crazy (i.e. schizophrenic)*.

For example, a man in analysis is reported by his wife to be persistently 'questioning the adjustment' of her younger sister, an insecure young woman, until the girl becomes increasingly anxious; he does this, evidently, by repeatedly calling her attention to areas of her personality of which she is at best dimly aware, areas which are quite at variance with the person she considers herself to be. The re-

pressions which have been necessary for the maintenance of a functioning ego are thereby weakened (without actual psychotherapy being available to her), and increasing conflict and anxiety supervene. Quite similarly, it can be seen that the inexperienced or unconsciously sadistic analyst who makes many premature interpretations is thereby tending to drive the patient psychotic—tending to weaken the patient's ego rather than, in line with his conscious aim, to strengthen that ego by helping the patient to gradually assimilate previously repressed material through more timely interpretations.

Or a person may stimulate the other person sexually, in a setting where it would be disastrous for that person to seek gratification for his or her aroused sexual needs; thus, again, a conflict is produced. We see this in innumerable instances from schizophrenic patients' histories, in which a parent behaved in an inordinately seductive way toward the child, thus fostering in the latter an intense conflict between sexual needs on the one hand, and rigorous super-ego retaliations (in line with the taboo of the culture against incest) on the other hand. This circumstance can also be seen as productive of a conflict in the child between, on the one hand, his desire to mature and fulfil his own individuality, and on the other hand his regressive desire to remain in an infantile symbiosis with the parent, to remain there at the cost of investing even his sexual strivings—which constitute his trump card in the game for self-realization—in that regressive relationship.

The simultaneous, or rapidly alternating, stimulation-and-frustration of other needs in addition to sexual ones can have, I believe, a similarly disintegrating effect. One male patient, emerging from a psychosis in which his intense ambivalent feelings toward his mother played a central part, became able to describe something of his childhood-relationship with her. The mother's rejecting attitude was high-lighted by his recollection that he had never seen her kiss his father, whom the mother had dominated and nagged mercilessly.

The patient remembered that there was one occasion when the mother had *started* to kiss her husband. This was at a time when, late in the son's childhood, his father was being rolled into the operating room of a hospital, for a major operation following a car accident. The mother leaned down as though to kiss her husband and the patient saw his face become suffused with joyous anticipation. Then the mother thought better of it, and straightened up. The patient described this with a desolate feeling-tone, as though he himself had experienced this sort of frustration at her hands many times in his own life.

Similarly, with the child's desire, as well as felt duty, to be helpful to (for example) a parent: frequently we find in the histories of schizophrenic patients that one or both the parents made chronic pleas for sympathy, understanding, and what we would call in essence therapeutic intervention, from the child, while simultaneously rejecting his efforts to be helpful, so that his genuine sympathy and desire to be helpful became compounded with guilt, rage, and, perhaps above all, a sense of personal helplessness and worthlessness. In this connexion, Bateson, Jackson, Haley & Weakland (1956) have described parental injunctions of a mutually contradictory or 'double bind' nature as being important in the aetiology of schizophrenia.

Another technique, closely related to the stimulation-frustration technique just described, is that of one's dealing with the other person upon two (or perhaps even more) quite unrelated levels of relatedness simultaneously. This tends to require the other person to dissociate his participation in one or another (or possibly both) these levels, because he feels it to be so crazily inappropriate that he should find himself responding in terms of that particular level, since it seems to be utterly unrelated to what is going on at the other, more conscious and overt, level.

For example, on one or two occasions in my years-long work with a physically attractive

and often very seductive paranoid schizophrenic woman, I have felt hard-put to keep from going crazy when she was simultaneously (a) engaging me in some politico-philosophical debate (in which she was expressing herself with a virile kind of forceful, businesslike vigour, while I, though not being given a chance to say much, felt quite strongly urged to argue some of these points with her, and did so); and (b) strolling about the room or posing herself on her bed, in an extremely short-skirted dancing costume, in a sexually inflaming way. She made no verbal references to sex, except for charging me, early in the hour, with having 'lustful', 'erotic' desires; from there on, all the verbal interaction was this debate about theology, philosophy, and international politics, and it seemed to me that the non-verbal interaction was blatantly sexual. But—and here is, I think, the crucial point—I felt no consensual validation (at a conscious level) from her about this more covert interaction; this non-verbal sexual interaction tended to appear as simply a 'crazy' product of my own imagination. Even though I knew there was a reality basis for my responding on these two unrelated levels, I still found it such a strain that I felt, as I say, as though I were losing my mind. An insecure child, engaged in such a broadly divided interrelatedness with a parent would, I think, suffer significant personality trauma in an oft-repeated situation of this sort.

Another technique, closely akin to that of relating to the other person upon two or more disjointed levels at once, is the sudden switching from one emotional wavelength to another, such as one finds so very frequently among the parents of schizophrenic patients. For example, one deeply schizophrenic young man's mother, a very intense person who talked with machine-gun rapidity, poured out to me in an uninterrupted rush of words the following sentences, which were so full of *non sequiturs*, as regards emotional tone, that they left me momentarily quite dazed: 'He was very happy. I can't imagine this thing coming over him. He never was down, ever.

He loved his radio repair work at Mr Mitchell's shop in Lewiston. Mr Mitchell is a very perfectionistic person. I don't think any of the men at his shop before Edward lasted more than a few months. But Edward got along with him beautifully. He used to come home and say [the mother imitates an exhausted sigh], "I can't stand it another minute!" The patient, for several months prior to his hospitalization, had spent most of his time at home in the company of his mother, and I thought it significant, in this same connexion, that during the early months of his hospital stay he showed every evidence (in his facial expressions and so on) of being assailed by upsurging feelings which changed in quality with overwhelming suddenness and frequency. For example, one moment his face would show a mixture of hatred and loathing, then he would suddenly jerk as though struck by some massive object, while his face showed now an intense grief.

My implication, that this phenomenon was partly a result of his long-continued exposure to his mother's poorly integrated personality, is not intended to rule out the possibility that the process worked in the reverse direction at the same time. On the contrary, I was impressed with the mother's evidencing a better integration after the patient had been out of the home for some time, and thought it entirely likely that during my above-mentioned interview with her, at the time of her son's admission, she was showing some of the after-effects of years-long exposure to an extremely poorly integrated, psychotic person, with whose capacity to assault one's own integration I myself became most uncomfortably acquainted in the course of my work with him. All this touches upon the matter of struggle, between child and parent or between patient and therapist, to drive one another crazy; I shall go into this matter later on.

The now-deceased mother of another schizophrenic man was described by the patient's siblings as having been completely unpredictable in her emotional changeability; for instance, she would return from the synagogue with a beatific expression on her face, as though she were immersed in some joyous

spiritual experience, and two minutes later would be throwing a kitchen-pot at one of the children. At times she was warm and tender to the patient, but would suddenly lash out at the child with virulent accusations or severe physical beatings. The patient, who at the time of my beginning therapy with him had been suffering from paranoid schizophrenia for some years, required more than three years of intensive psychotherapy to become free of the delusion that he had had not one mother but many different ones. He would object repeatedly to my reference to 'your mother', protesting that he never had *one* mother; once he explained, seriously and utterly convincingly: 'When you use the word 'mother', I see a picture of a parade of women, each one representing a different point of view.'

A continual, unexpected switching from one conversational topic to another without, necessarily, any marked shift in feeling-content is in itself a mode of interpersonal participation which can have a significantly disintegrating effect upon the other person's psychological functioning, as can be attested by any therapist who has worked with a patient who shows prolonged and severe confusion.

Each of these techniques tends to undermine the other person's confidence in the reliability of his own emotional reactions and of his own perception of outer reality (a formulation for which I am indebted to Dr Donald L. Burnham). In one of the previously mentioned papers by Johnson *et al.* (1956) we find the following pertinent description of the schizophrenic patients' childhood relationships with their parents: '...When these children perceived the anger and hostility of a parent, as they did on many occasions, immediately the parent would deny that he was angry and would insist that the child deny it too, so that the child was faced with the dilemma of whether to believe the parent or his own senses. If he believed his senses, he maintained a firm grasp on reality; if he believed the parent, he maintained the needed relationship, but

distorted his perception of reality. Repeated parental denial resulted in the child's failure to develop adequate reality testing.*

The subject about which I am writing in this paper ties in with one from a quite different field of human activity: international politics and warfare. I refer to the subject of brainwashing and allied techniques. In reading a recent and valuable book upon this subject by Meerloo, entitled, *The Rape of the Mind* (1956), I was repeatedly impressed with the many similarities between the conscious and deliberate techniques of brainwashing which he describes, and the unconscious (or predominantly unconscious) techniques of thwarting of ego-development, and undermining of ego-functioning, which I have found to be at work in the experiences, both current and past, of schizophrenic patients. The enforced isolation in which the brainwashee exists—isolated from all save his inquisitor(s)—is but one example of these similarities; in the life of the to-be-schizophrenic child, a regular accompaniment of the parent's integration-eroding kinds of behaviour is an injunction against the child's turning to other persons who might validate his own emotional reactions and assure him against the parent-inspired fears that he must be 'crazy' to have such 'irrational' reactions to the parent.

Meerloo's book describes brainwashing and allied techniques as occurring in the form of (a) deliberate experiments in the service of totalitarian political ideologies; and (b) cultural undercurrents in our present-day society, even in politically democratic countries. My paper portrays much these same techniques as occurring in a third area: the lives of schizophrenic patients.

* One of my patients, who throughout his childhood was told, 'You're crazy!' whenever he saw through his parents' defensive denial, became so mistrustful of his own emotional responses that he relied heavily, for years, upon a pet dog to let him know, by its reaction to this or that other person whom he and his pet encountered, whether the person were friendly and trustworthy, or hostile and to be on guard against.

B. MOTIVES BEHIND THE EFFORT TO DRIVE THE OTHER PERSON CRAZY

A mode of interpersonal participation which tends to drive the other person crazy can be based, seemingly, upon any one of a wide variety of motives; in any single instance, probably a complex constellation of various motives are at work. These motives range all the way, apparently, from intense hostility on one end of the scale to, at the other end, desires for a healthier, closer relatedness with the other person, and desires for self-realization. I shall start with those more obvious motives at the former end of the scale.

(1) The effort to drive the other person crazy can consist, predominantly, in the psychological equivalent of murder; that is, it can represent primarily an endeavour to destroy the other person, to get rid of him as completely as if he were physically destroyed. In this connexion, it is interesting to note that whereas our legal system reserves its severest punishment for him who commits physical murder, it metes out no—or at most negligible—punishment for psychological 'murder', for destroying another person psychologically by driving him 'crazy'. In the knowledge of the average person who is unacquainted with the details of legal procedure, the only legal penalty in this area is the tangentially relevant and entirely unfrighting legal charge of 'mental cruelty' which, he knows, is not infrequently conjured up as an excuse to make a high percentage of divorces obtainable.

I do not mean to imply that I wonder at this legal state of things, or that I suggest any change in the law in this regard; I think it would be impracticable to set out to prove, legally, that one person had contributed significantly to another person's 'going crazy'. My point is that this state of things does exist in our legal system, such that whereas one has a reason to feel deterred, by law, from physical murder, one has practically no reason to feel similarly deterred from what might be thought of as psychological murder.

It should be noted, further, that a psychosis

which is severe enough to require years-long hospitalization does indeed serve to bar the patient from continued participation in the life of, for instance, a family, almost as effectively as would death itself. It is not unheard of for the parents of a long-psychotic, hospitalized child to let it be known that the child has died, and it is much more frequent that the family members still at home avoid making references to the patient, in their everyday life with friends and associates, and avoid consulting or informing the patient concerning family crises, very much as though the patient had 'passed away'.

As an example of this kind of motive, I shall cite certain data from my work with a young woman who had been hospitalized for more than three years for a schizophrenic illness, and who by this time had become able to tell me some details about her life in her family prior to the onset of her illness.

She had one sibling, a sister two years younger than herself. Both girls were good looking; both had been strongly indoctrinated with the view, from their mother and father, that a girl's only *raison d'être* is the acquisition of a socially prominent and wealthy husband; both were much involved in fantasies of being the wife of the father, since their mother accepted a much-derogated role in the family. They were, therefore, intensely and openly competitive with one another.

My patient, in one of her psychotherapeutic sessions, reminisced about a time (not more than two years prior to her first hospitalization) when her sister had been jilted by a boy friend whom the sister had introduced to a supposed friend, named Mary. She said that for about a year after that, her sister wore dark glasses and 'went around the house talking about suicide', and weeping. The patient said that the glasses 'were driving her [i.e. the sister] crazy'. She also added, 'My sister used to say she read a lot so that she wouldn't go nuts', and commented to me that 'the jealousy and hatred . . . and all the teasing . . . make a person wild.' She spoke of 'how jealous Sarah [the sister] was of Mary', giving me to think that she was about to say 'of me', but shifted to

'of Mary'; I got the distinct impression, from other things she said, that the jealousy between herself and her sister was intense during that period. I noticed that when she spoke, from time to time, of the suffering her sister had evidenced, a sadistic smile repeatedly came over her face. She said at one point that 'If two people each want the same thing' they're bound to have hatred and jealousy toward one another, and later spoke of how much hatred and jealousy one has toward somebody who is standing in the way of something or somebody one wants. I commented, here, casually, that naturally one feels like killing the other person, getting rid of them. She replied, 'Killing—that isn't allowed—', as if she had already considered that but had come up against the fact that, for some reason incomprehensible to her, this was forbidden.

Parenthetically, this girl's case history describes her having verbally threatened to murder her sister—'I'll get you in the back when you're not looking'—and having picked up a hammer and threatened to kill her mother with it. The sister, who had been married a few months after the patient's initial hospitalization, was afraid to let the patient visit her for fear the latter would kill the sister's small baby; in short, the family took her threats of murder quite seriously.

Now, when she said thoughtfully, during this therapeutic session, 'Killing—that isn't allowed—', she added significantly, '—but there are other ways'. On another occasion, while telling of her sister's depressive symptoms, she fell to reciting the words of the nonsense song 'Mairzy Doats', which had been popular during that era. She puzzled, in her chronically confused way, over the word 'Mairzy', saying twice that sometimes the word is 'Mairzy' and sometimes it is 'Mary', giving me every impression that during the sister's depression she had tormented the sister by asking her about this song, often using the hated word 'Mary', the name of the sister's former friend who had taken from her, and eventually married, her steady boy friend.

This material is too long to reproduce in

full here; but, in essence, it should be reported that the patient had evidently felt herself to be in a desperate struggle with the sister as to which one would drive the other crazy first. On one occasion the patient recalled, with obvious anxiety, 'Sarah said I had something to do with it', the 'it' referring to Sarah's depression, and she quoted Sarah as saying, 'I hope you never get this', which evidently had an ominously threatening connotation to the patient. I got every impression that she felt guilty about the sister's illness, felt that the sister blamed her for it, and feared that the sister would vengefully cause her to be similarly ill, in retaliation.

This touches upon the subject of what I call 'psychosis wishes', entirely analogous to 'death wishes'. On several occasions, when working with patients who have had an experience, earlier in life prior to their own illness, of a parent's being hospitalized because of a psychotic illness, I have found that the patients show guilt about repressed 'psychosis wishes', entirely similar to 'death wishes' which are productive of guilt in persons who have lost a hated parent through death. The patients who show this guilt over 'psychosis wishes' show every evidence of feeling that they were once successful in a mutual struggle with the parent, in which each was striving to drive the other crazy, and the subsequent appearance of their own psychosis seems to be attributable in part to guilt, and fear of the parent's revenge, stemming from that duel in previous years. In the case which I have been describing, the sister was not actually hospitalized; but in other respects the circumstances were those which I have just outlined as regards patients whose mother or father, in their childhood, had been hospitalized with psychosis.

In this girl's family life, the particular mode of interpersonal participation with which I am dealing in this paper—the effort to drive the other person crazy—seems to have been a customary mode, over the years, of the various family members' interaction with one another. I shall cite but one more portion of the

available data. During childhood and adolescence, she had experienced a great deal of anxiety about her teeth, partly on account of her having lost some of them in a playground accident. Her father used to frighten her, time and again, by telling her teasingly, 'I'm going to take your teeth out and use them for golf tees.' For the first several months after her admission to Chestnut Lodge she was, in the words of the psychiatric administrator here, 'crawling with terror', incessantly demanding reassurance that no harm would come to her teeth and to various other body-parts. After several years of therapy she made clear to me her conviction that her family members, each of them possessing much hatred and envy of her, had acted in concert to drive her crazy and thus rid their home of her presence, and although this is by no means an accurate total picture of what had happened, it is, I believe, an accurate description of a part of what had happened.

(2) The effort to drive the other person crazy can be motivated predominantly by a desire to externalize, and thus get rid of, the threatening craziness in oneself. It is well known that the families of schizophrenic patients have a proclivity for dealing with the patient as being 'the crazy one' in the family, the repository of all the craziness among the various other family members. Hill's previously mentioned book (1955) contains some valuable observations which help one to grasp the concept that the patient's craziness consists, to a significant degree, in an introjected crazy parent (usually, in Hill's experience as in my own, the mother), a parent who now, introjected, comprises the predominance of the patient's own irrational and cripplingly powerful superego. To the extent to which this process takes place in the mother's relationship with her child, she succeeds, in effect, in externalizing upon him her own 'craziness'. My concept of one's striving to drive the other person crazy emerges naturally, as I mentioned earlier, from many of the interesting formulations at which Hill has arrived.

I have presented elsewhere (1958) my view

that a most important ingredient in the above-described mother-child relatedness is the child's genuine love and solicitude for the mother, love and solicitude of such a degree as to impel him to collaborate with her in this pathological integration. He loves her so deeply, in short, that he sacrifices his own developing individuality to the symbiosis which is so necessary to her personality-functioning.

(3) Another motive behind this effort which I am describing is, in many instances, the wish to find surcease from an intolerably conflictual and suspenseful situation. If one's mother, for example, recurrently holds before one the threat that she will go crazy, with the implication that it will be catastrophic for oneself if this indispensable person were thus to remove herself from the situation, one may well be tempted to do one's utmost to *drive* her crazy and thus to cut, oneself, the thread that holds this sword of Damocles over one's head; if it is so apt to fall in any case, one can at least salvage the satisfaction of feeling that it is one's own hand which has effected the unavoidable catastrophe.

We see, every day in our work in psychiatry, that patients tend to bring upon themselves any catastrophe which is sensed as being inevitable, in their effort to diminish intolerable feelings of helplessness and suspense in the face of it.

The tormentingly insecure nature of the ever-ambivalent symbiotic relatedness which existed between the schizophrenic, in infancy and childhood, and his mother or father, has been described by Hill (1955) Arieti (1955), Bowen (1956) and myself (1951). Any one who has participated in a long-continued therapeutic endeavour with a schizophrenic patient has experienced at first hand, re-enacted in the transference relationship between the patient and himself, the intensely ambivalent—*mutually* so—relatedness which existed between the patient and the pathogenically-more-significant parent.

(4) With surprising frequency, one finds, both in patients' histories and, much more impressively, in the unfolding of their child-

hood relationships with the parents in the evolution of transference phenomena, that they had come to the discovery, over the course of the years of their childhood, that one or another of the parents was, so to speak, a little crazy. They felt—often rightly, I think—that the evidence of the parent's craziness was so subtle, or so hidden from public display and released only in their own relationship with the parent, that only the child himself was aware of the full extent of it. In these circumstances, this knowledge remains as a guilt-laden secret in the child; he strongly tends to feel somehow responsible for the fact of the parent's craziness, and heavily burdened by both the craziness—since the parent seeks satisfaction for the psychotically expressed needs from this child in particular—and by his own knowledge of its existence.

Thus the setting is ripe for his becoming tempted to foster the parent's becoming sufficiently openly psychotic—tempted, that is, to drive the parent into craziness which will be evident to others beside himself—so that the family and the larger community will share his own burden. The patients one encounters who have had this kind of pre-psychotic experience are much more numerous than those who have had the experience of one or another parent's becoming openly psychotic and requiring hospitalization.

In my presentation of this formulation, I do not lose sight of the likelihood that a patient who is himself struggling against a developing psychosis will project his own threatening 'craziness' on to one or another parent. This happens often and even, I believe, regularly. But the process which I have described occurs, not infrequently, in addition.

(5) One of the most powerful and frequently encountered of the motives behind the effort in question is a desire to find a soul-mate to assuage unbearable loneliness. In the case of every one of the schizophrenic patients with whom I have worked long and successfully enough to perceive the childhood relationships relatively clearly, this motive evidently had been at work in whichever parent had inte-

grated a symbiotic relatedness with the child. The precariously integrated parent is typically a very lonely person who hungers for someone to share her (or his) private emotional experiences and distorted views of the world.

The following report by an attendant, concerning his conversation with a 28-year-old male schizophrenic patient, shows this motive at work:

Carl had been quiet—seemingly depressed all morning—when he suddenly started to talk about his mother's illness. Said he envied his older sister because she didn't have to bear the brunt of his mother's illness. (The sister is not sick.) Said that his mother 'tried out' her paranoid ideas on him. Would go around the house, pull down the blinds, check to see if any one were near, then tell him what apparently were full blown paranoid ideas about the neighbours and friends. [He] very philosophically announced that he felt she needed company in her illness—that she felt so lonely that she had to use him in this way... [He] has ideas people are talking about him, and voices these ideas in a naïve, forthright manner.

This parental motive is reflected in patients' fanatical loyalty to the parent, a loyalty which gives way, in the psychotherapy of chronic schizophrenia, only after years of arduous work by patient and therapist. One finds evidence of it, too, in the frequency with which deeply ill patients hallucinate this parent in an idealized form, an idealized parent often, from what I have discerned in my own work, split into two, one the personification of evil and the other the personification of loving protectiveness. With the most deeply ill patients it may require many months of stressful therapeutic labour before the therapist begins to assume, in the patient's view of him, a degree of libidinally cathected reality which can compare with that of the hallucinatory, but to the patient immediately and vividly real, parent-images. And one finds evidence of it, of course, as has already been indicated earlier, in the parent's fighting tooth-and-nail, by every means at his or her disposal, against the patient's and therapist's collaborative effort toward the patient's becoming free from his

magically 'close', magically 'mutually understanding', two-against-the-world relatedness with the parent.

In what I have just said, no acknowledgement has been paid to the parents' contrasting, and healthy, desire to help their child reach true maturity, a fulfilment so at variance with the kind of subjectively mutually-omnipotent and celestially loving, but in actuality intensely ambivalent and psychotic, relatedness which I have described. Parents are never devoid of such a healthy parental desire and often, in my experience, that desire is sufficiently strong to enable them to make indispensable contributions to the endeavour in which patient and therapist are engaged. But it remains true, none the less, that this infantile-omnipotent relatedness between the 'sickest', least mature areas of the parent's personality on the one hand, and the patient's personality on the other hand, constitutes the greatest obstacle, in my experience, to the patient's becoming well.

All this becomes reproduced in the transference-development of an ongoing patient-therapist relationship, and the therapist inevitably becomes deeply immersed in the subjective experience of magical closeness and shared omnipotence with the patient. The enthralling nature of this phase accounts in many instances, I believe, for the great length of time consumed by the over-all treatment of these patients. The therapist gets at least one foot into the psychological process in which the patient himself is engaged, namely the process of maintaining a split between his 'good self' and his 'bad self', as well as a split between the 'good other person' and the 'bad other person'; generally, in fact, the therapist gets both feet into this process, for *X* number of months. Then both he and the patient spend much time basking in a purely 'good' experience of himself and of the other person, while the 'bad' elements in the relationship are maintained in a state of repression and projection on to the world outside the nest. The therapist, in experiences of this sort, learns at first hand how strong was the lure

offered to the patient in childhood by the parent, the lure to share the delights of being 'crazy' along with the parent.

(6) Something of the complexity which exists in an interpersonal relationship, the complexity of the true state of affairs which renders any attempt to describe that relationship (such as I am attempting here) a crude oversimplification, becomes evident when we consider this next motive.

A mode of interpersonal participation which bears all the earmarks of an effort to drive the other person crazy may be powerfully motivated, in actuality, by a conscious or unconscious desire to encourage the other person into a *healthier* closeness, a better integration both interpersonally, with oneself, and intrapersonally, within himself. In fact, successful psychotherapeutic intervention often takes on precisely this outward form.

Here, that is, the conscious or unconscious effort is to activate dissociated or repressed elements in the other's personality, not with the goal of his ego's becoming overwhelmed by their accession into awareness, but rather with the goal of his ego's integrating them. I do not mean, of course, that the initiator of this kind of participation conceptualizes all this, plans it all out in his mind in any such detail.

This fostering of the other person's intrapersonal and interpersonal integration or self-realization is a part of the essence of loving relatedness as defined by the philosopher-theologian Martin Buber (Friedman, 1955). He refers to this as 'making the other [person] present' and, when it occurs mutually, as 'mutual confirmation': and he expresses his conviction that '... The help that men give each other in becoming a self leads the life between men to its height...' (Limentani, 1956).

To put it in other words, it seems to me that the essence of loving relatedness entails a responding to the wholeness of the other person—including often (particularly in relating to a small child or to a psychiatrically ill adult, but to a lesser degree in relating to all other persons also) a responding in such

fashion to the other person when he himself is not aware of his own wholeness, finding and responding to a larger person in him than he himself is aware of being.

Thus, to focus again more specifically upon the seeming effort to drive the other person crazy, we find that this effort can be very close to, and can even be comprised of, an effort to help the other person toward better integration, which latter effort can be considered the essence of loving relatedness. A genuine effort to drive the other person crazy—to weaken his personal integration, to diminish the area of his ego and increase the area of dissociated or repressed processes in his personality—can be considered, by contrast, precisely the opposite of the kind of loving relatedness which Buber describes.

I surmise that in many instances of a parent's fostering his or her child's 'going crazy', the psychosis in the offspring represents a miscarriage of the parent's wish, conscious or unconscious, to help the child toward a better, more mature integration. One cannot always know the precise ego-capacities of the other person, as any therapist can attest, and it may well be that parents often perform acts analogous with those interventions of a therapist which are ill-timed or otherwise ill-attuned to the needs of the patient's ego, and which have, instead of the desired effect of further integration in the patient, a disintegrating effect.

I think it significant in this regard that, in very many instances of the outbreak of psychosis, the precipitating circumstances, whatever they may be, have led the patient to become aware of truths about himself and his relationships with others in the family, truths which are actually precious and long-needed, truths which could provide the basis for rapid ego-growth, rapid personality-integration. But they come too fast for the patient's ego to assimilate them and the ego regresses, recoiling from what is now, in its effect, an opened Pandora's box. Thus what could have become—and what in probably a great many instances does become, in persons who never get to a psychiatrist—a valuable, creative,

integrative growth experience, becomes an experience of developing psychosis, as various pathological defences (delusions, hallucinations, depersonalization, and so on) become erected against the awareness of those truths.

In psychotherapy the therapist is often called upon to contribute, in skilfully dosed and skilfully timed increments, the very kind of participation which would, if given less skilfully (whether by reason of inexperience or by reason of his orientation toward the patient being a predominantly hateful rather than a predominantly loving one), have an effect precisely opposite to the therapeutically desirable one. For instance, premature interpretations may have a disintegrating rather than an integrating effect upon the patient.

(7) The next motive which I shall discuss can be seen in connexion with a point made prominently by Hill, the point that the mother of the schizophrenic keeps before the child the threat that she will go crazy if he becomes an individual by separating himself, psychologically, from her.

The relevant motive, then, is this: the child's own desire for individuation may be experienced by him as a desire to drive the mother crazy. The mother reacts to his desire for individuation as an effort to drive her crazy; so it seems to me entirely natural that the child himself should be unable to distinguish between his own normal and precious striving toward individuation, on the one hand, and on the other hand a monstrous desire—which latter the mother repeatedly reacts to him as evidencing—to drive his mother crazy.

Such a state of psychodynamic affairs is entirely analogous, I think, to that which obtains in a situation where the mother indicates that if the child really grows up, it will kill her; there, as one finds in clinical work, the child comes to experience his normal desires to become an individual, as being monstrous desires to murder his mother. Hill makes this latter point in his volume.

If, in looking a bit further into the child's relation with such a mother as Hill describes, we shift the frame of reference to visualize

the *struggle between* mother and child to drive one another crazy, another interesting point emerges: the mother's ostensible efforts to drive the child crazy can be seen as containing, probably, a nucleus of laudable motivation, though unformulated as such by her, to help her child become an individual. It is probable that, in the mind of such a mother, the concept of psychological separateness, of individuality, is to such an extent equated with craziness, that she cannot conceptualize this motive as a wish to help her child become an individual. But it may well be that some bit of healthy mother in her senses that the child needs something which she is not providing, something utterly essential, and that it is this part of her which ostensibly tries to drive the child crazy—tries, in actuality, to help the child become an individual.

In the psychotherapeutic relationship we find that, as a natural consequence of this past experience of the patient, he tends to react to his own developing individuality, his own ego-growth, as anxiety-arousing craziness; and the therapist (in the transference-position of the mother at this phase of the work) tends to experience this anxiety too. Thus both participants tend unconsciously to perpetuate a symbiotic relatedness with one another, out of mutual anxiety lest the patient 'go crazy' completely—lest, in truth, the patient emerge from the symbiosis into a state of healthy individuality. This formulation is in line with Szalita-Pemow's comment (in a personal communication) that 'The [schizophrenic] patient's individuality resides partly in his symptoms'.

(8) The final motive is actually, in my experience, most often the most powerful of all these motives; my mention of it at this juncture is brief because it has already been touched upon in discussing motive (5) above, and because so much of this paper's final pages will be devoted to it. This motive is the attainment, perpetuation, or recapture of the gratifications inherent in the symbiotic mode of relatedness. More often than not, the effort to drive the other person crazy, or to perpetuate his craziness, can be found to rest primarily upon both

participants' unconscious striving for the gratifications which the 'crazy' symbiotic mode of relatedness, despite its anxiety- and frustration-engendering aspects, offers.

I shall not attempt to discuss other possible motives behind the effort to drive the other person crazy. One can undoubtedly find others, and some of them may be of as widespread importance as those I have described. But the eight which I have mentioned are, in my experience at least, the most frequently occurring and powerful ones.

C. THE PATIENT-THERAPIST RELATIONSHIP

A considerable portion of the clinical experience which has led to this paper's central hypothesis has consisted in reports about, and observations of, patients' relatedness with their parental family-group and with the group of patients-and-personnel on their hospital ward; if space allowed, I could present data indicating that in each of these arenas, the patient's integration with the group takes the form, in many instances, of a mutual struggle to drive the other person crazy.

But, since I consider that fundamentally the same psychodynamic processes are at work there, the only fundamental difference being that they are there operative in a group, rather than dyadic, setting, and because my main interest is in individual psychotherapy, I shall confine my remaining remarks to the context of the patient-therapist relationship.

In my experience, it is in the patient-therapist relationship that one can discern most clearly this mode of interaction, the effort to drive the other person crazy. Specifically, one can find this type of relatedness predominating during one particular phase of the schizophrenic patient's evolving transference to the therapist, a phase in which there is reconstituted, between patient and therapist now, an earlier *struggle between* patient and parent to drive each other crazy. From my own therapeutic work, and from what I have observed of other therapists' work here at Chestnut Lodge, I have obtained the impression that any successful course of psychotherapy with a schizophrenic patient

includes such a phase. During it the therapist becomes, in most instances I believe, deeply involved in this struggle, such that he does indeed feel that his own personal integration is in real jeopardy of a greater or lesser degree. The therapist's necessary participation in this phase of the transference-evolution is one of the main elements in psychotherapy with schizophrenics which make this work at times so stressful to pursue.

One of my male schizophrenic patients expressed his conviction to me, for more than two years, that, as he put it, 'You're kind of *strange*, Dr Searles'; 'You're crazy, Dr Searles'; 'You think peculiarly'; and he would say knowingly, 'You don't express yourself to other people the way you do to me, do you?' In the development of this man's transference to me as a mother-figure, there was revealed beautifully the fact that, in earlier years, he had repeatedly tested his mother's sanity by leading the mother into various situations and then seeing whether she reacted in a normal, or abnormal, fashion. The mother, who had died a few years before the patient's hospitalization, had been a highly schizoid individual with whom he had been involved, over many years, in a typically symbiotic relationship. The other family members, highly prestige-conscious people, had maintained a barrier of protectiveness and scorn around the eccentric mother and this son, so like the mother in that eccentricity.

In my work with this man, the struggle to drive one another crazy was re-enacted with unusual intensity. He did an almost incessant amount of testing of me, such as he evidently had done in earlier years with his schizoid mother, in such a way as to bring out evidence to support his persistent suspicion that I was slightly, or more than slightly, cracked. He reiterated, for years, maddeningly bland stereotypes, labelling himself as thoroughly healthy and good, and myself as warped and evil, with a kind of eroding tenacity; and at times he picked at me in the same baiting, sarcastic, accusing way that his mother evidently had employed toward him, to such a

degree that I could scarcely make myself remain in the room. He accused me, time and time again, of driving him crazy;* after my having gone through a number of hours with him in which I had to struggle with unaccustomed effort to maintain my own sanity, it began to occur to me that this oft-reiterated accusation of his—that *I* was trying to drive *him* crazy—might involve some projection.

In the course of an hour with a 24-year-old schizophrenic woman I became assailed with feelings of confusion and unreality, when this patient, a luxuriantly delusional person, was reading to me from an instruction book concerning the Japanese game of 'Go'. She appeared to find some hidden meaning in almost every word and even in almost every syllable, looking at me significantly, with a sarcastic smile, very frequently, as though convinced I was aware of the secret meanings which she found in all this. The realization came to me, with a temporarily quite disintegrating impact, of how threatened, mistrustful, and isolated this woman was. What she was doing with me compares very closely with her mother's taking her to movies, during her childhood, and repeatedly commanding her, 'Now, *think!*', which the patient took—correctly, I believe—as the mother's command for the daughter to perceive the same secret, special meanings in the course of the movie which the mother, an actively psychotic person throughout the girl's upbringing, found in the picture. The patient had been quite unnerved by this impossible task (whose 'successful' accomplishment would have meant her sharing her mother's

psychosis), just as I felt unnerved during that session, with her reading. Also, on a later occasion she described her own having read to her mother in exactly such a fashion for hours on end while the mother was doing housework, and it was evident to me that she had derived much sadistic satisfaction from her own being able to drive her mother to distraction by that method. Many times, similarly, I saw her sit back with a triumphant smile after she had succeeded in making me thoroughly bewildered, and more than a little insecure, with her chaotic verbalizations of delusional material.

The woman I have just mentioned had been told over and over again, by various members of her family ever since she was a small child, 'You're crazy!'—whenever, as she herself remembered it, she pressed any one of them for information to resolve the confusion which, to some extent, all children experience often when they are exposed to unfamiliar and complex situations. She described it to me once that: 'Whenever I'd open my mouth, six or eight of them [i.e. other members of her unusually large family] would jump down my throat and tell me I was crazy, until I began to wonder whether I really was losing my mind.' It became quite clear that a mutual struggle to drive one another crazy had gone on between her on the one hand and other family members on the other hand. It had ensued with particular intensity between herself and her mother, an extremely changeable person (as corroborated by one of the patient's brothers) whom the patient was convinced, for years after beginning therapy with me, was not one person but many. Of this mother, she once made to me this statement, significantly indicative of the kind of struggle I have described: 'They used to say, "You're psychosomatic! If you don't watch out, you'll wind up in a mental hospital!" That's the way *they* were and they wouldn't admit it.'

There were hints in my work with this woman, however, that her efforts to drive me (as a mother-figure in the transference during this phase of the therapy) crazy were motivated

* A schizophrenic man, after several months of mutism, when he began talking to his therapist said, repeatedly, in anxious protest, 'You talk too queer. . . . You're too crazy.' Following a visit from his mother, he anxiously asserted that his mother wanted to kill him, and declared that his mother had made him sick and had driven the patient's brother (a monk) to the monastery. A few months later on, the same feelings came out in accusations to the therapist. 'You wanted to kill me. You made me sick. . . . crazy thoughts. You talk too queer.'

at times not primarily by sadistic pleasure in rendering me more or less disorganized, nor by a need to externalize upon me her own psychosis, but, rather, by genuine solicitude for me. At such moments the interaction between us was such as to make clear that I was in the position, as she saw me, of a mentally ill mother who needed treatment which she herself felt helpless to provide me—entirely similar to the situation which had obtained during her childhood, in her relatedness with a psychiatrically ill mother who never obtained the benefit of professional treatment for her chronic ‘ambulatory’ schizophrenia.

On one occasion when this facet of the transference was in evidence, the patient protested, late in a session in which we had been exchanging views quite actively: ‘Why don’t you go to a state hospital?—that’s what you’ve been asking for, all the time you were talking.’ She said this in a tone not of hostility but of solicitude and helplessness, as if she were being held responsible for placing me in a state hospital, and felt utterly helpless to carry out this obligation. In another hour two weeks later she demanded, ‘When are they going to send you to a state hospital? . . . I know you’re trying to get to one.’ In these instances, I assume that one factor at work was a projection of her own unconscious desire to be sent to a state hospital. None the less, all this fits so precisely with the relatedness which had obtained between herself and her mother, and moreover there were such numerous additional indications that she was responding to me as being her mother from her childhood, that I was convinced of the above-described transference significance of her responses.

The above examples are predominantly illustrative of *patients’* efforts to drive their therapist crazy. My clinical material, from both my own therapeutic work and my observations of that of fellow therapists, indicative of the *therapist’s* own comparable effort, suggests that therapists utilize (largely unconsciously, I again emphasize), just as do patients,

the whole gamut of modes or techniques which I have described earlier in this paper; and the range of underlying motives is seemingly as wide for therapists as for patients.

In any single instance, the therapist’s striving in this direction can be found, I believe, to arise from two sources: (a) the nature of the patient’s transference—namely, a driving-and-being-driven-crazy type of relatedness—to him, such that he is inevitably drawn, to some degree, into a state of feeling, and a mode of overt relatedness, which is complementary to that transference; and (b) a character-trait in the therapist, transcending his relationship with this particular patient, in the form of an unconscious tendency (of, undoubtedly, widely varying strength among various therapists, but probably not totally absent from the enduring constellation of personality-traits of any therapist), to drive the other person crazy—*whatever* other person, that is, with whom he establishes a significantly close relationship.

So then, when we find, upon examining any particular patient-therapist relationship, that the relationship at this stage is characterized predominantly by a mutual struggle between the two participants to drive one another crazy, it is probable that the therapist’s behaviour of this sort is based partially—and, I think, in most instances predominantly—upon the first-described kind of ‘normal’ therapist-responsiveness to the patient’s transference.

But in, I think, a significant percentage of such instances, the second of the sources which I have mentioned—sources for the therapist’s behaviourally participating in this struggle—also plays a greater or lesser part. I discovered conclusive proof of such a character-trait in myself, to my great dismay, late in my personal analysis (about seven years ago)—a trait which I found to be in operation not only with regard to one or two of the patients with whom I was working at the time, but with regard to all of them, as well as with regard to innumerable other persons—relatives, friends, and acquaintances. The following general considerations are suggestive of a fairly wide distribution of

such a character-trait among psychotherapists and psychoanalysts:

(1) An obsessive-compulsive type of basic personality structure is certainly not rare among therapists and analysts. I am not convinced that such a personality structure predominates among us; but any one's informal observations suggest that it is probably to be found at least as frequently among us as among the members of the general population, in our culture which places so many premiums upon such obsessive-compulsive character traits as orderliness, competitiveness, intellectualization, and so on.

It is well known that one of the major defence mechanisms of the obsessive-compulsive is reaction formation. It should not be surprising, then, to find that the choice of a profession, on the part of a significant number of psychotherapists and psychoanalysts, has been founded partially on the basis of reaction formation against unconscious wishes which run precisely counter to the conscious endeavour which holds sway in their daily work. That is, just as we would not be surprised to find that a surgeon brings forth, in the course of his psychoanalysis, powerful and heretofore-deeply-repressed wishes to physically dismember other persons, so we should be ready to discern the presence, in not a few of us who have chosen the profession of treating psychiatric illness, of similarly powerful, long-repressed desires to dismember the personality-structure of other persons.

(2) To extend the line of—admittedly hypothetical—reasoning which has been presented in (1) above, it is understandable that in the training analyses of persons who have chosen psychotherapy or psychoanalyses as a profession, the analysand would encounter great resistance to the recognition, in himself, of such desires as those in question here—desires to drive other persons crazy—since these desires run so directly into conflict with his genuine and powerful interests in helping to *resolve* psychiatric illness. Hence such unconscious desires—such a personality-trait, that is—understandably might tend to escape detection,

and thoroughgoing resolution, in the training analysis, and the choice of a profession might never be revealed as constituting part of the analysand's struggle against his unconscious wishes to foster personality-distintegration in other persons.

I think all this might be described most accurately as follows: desires to drive the other person crazy are a part of the limitlessly varied personality-constellation of emotionally healthy human beings; therapists' and analysts' choice of a profession is suggestive that, at least in some instances where the personality-structure is of an obsessive-compulsive type, the individual is struggling against more-than-normally-strong unconscious desires of this particular kind; and finally, because therapists and analysts are engaged in the particular life-work to which they are devoting themselves (the relief of psychiatric illness), it is especially difficult for *them* to allow themselves to recognize the presence, in themselves, of these *qualitatively normal* desires.

(3) So many of us show a persistent readiness to regard this or that kind of functional psychiatric illness, or this or that particular patient, as 'incurable'—in the face of, by now, convincingly abundant clinical evidence to the contrary—that one must suspect whether this proclivity for the adoption of an unscientifically 'hopeless' attitude masks, in actuality, an unconscious investment in keeping these particular patients fixed in their illnesses. In raising this point, I do not wish to minimize the very great difficulties which stand in the way of recovery for many psychiatric patients; on the contrary, it is my first-hand experience with facing such difficulties, in work with chronically psychotic patients, that makes me feel it all the more important for us to bring into this formidable task as few as possible additionally-complicating factors of our own.

I have seen, by now many times over (in my work with chronically psychotic or neurotic patients, in my supervisory experience with approximately twenty other therapists at Chestnut Lodge and elsewhere, and in listening

to staff- or seminar-presentations by many additional therapists) how very prone we are to the development of an attitude of hopelessness, in the course of our work with a patient, as a means of unconsciously clinging to the denied, but actually profoundly valued, gratifications which we are obtaining from a symbiotic mode of patient-therapist relatedness. In this phase, we tend to fight tooth-and-nail, however unwittingly, against the patient's making a major step forward—a step which something in us senses to be in the offing. Time after time, a major forward move in therapy is preceded by such a phase of hopelessness on the part of both patient and therapist, a hopelessness which can now be seen, in retrospect, as a matter of their mutual clinging to their symbiotic mode of relatedness with one another.

There have been, by now, many articles and books written which emphasize the pathogenic significance of such a mode of relatedness in the patient's—especially the schizophrenic patient's—upbringing; but I think we have underestimated the intensely gratifying elements of that mode of relatedness, a kind of relatedness which allows each participant to luxuriate in feelings of infantile satisfaction as well as in omnipotent-mother fantasies. I think that one of the great reasons why schizophrenia is so difficult to resolve is that the therapist finds so much inner resistance against helping the patient to move out of the reconstituted patient-parent symbiotic relatedness in the transference. Not only the patient, but the therapist also, tends to find the prospective fruits of a more mature relatedness *just barely*—if even that—worth the relinquishment of the symbiotic relatedness which, despite its torments, affords precious gratifications also.

Whenever I have been able to acquire up-to-the-minute, detailed data about these situations I have found, as one might expect, that the mutual struggle between patient and therapist to drive one another crazy occurs on the threshold of what, as later events prove, is an unusually big forward step for the patient

in therapy. It is as though both of them fight, via a recrudescence of their mutual driving-crazy, symbiotic techniques, against the upsurge of this favourable step in the therapy.

I do not wish to leave the impression that the therapeutic road, after one such break-through, consists in nothing more than a straight, wide, smooth home-stretch. In the working through, in the transference, of the patient's symbiotic relatedness with the mother, this same struggle has to be gone through again and again. Although in subsequent repetitions it tends to occur with less disruptive severity, the therapist regularly finds himself susceptible to feeling the same black despair, the same sensation of being driven utterly mad by this impossible patient, time after time at the thresholds of successive stages in the loosening of the symbiotic relatedness. This may be compared with the foetus' becoming anatomically separate from the mother: not merely one, but a long series, of labour pains is necessary before the baby fully emerges. Of tangential interest, here, are the following remarks by Margaret Little in a paper entitled, 'Counter-transference and the patient's response to it' (1951).

Consciously, and surely to a great extent unconsciously too, we all want our patients to get well, and we can identify readily with them in their desire to get well, that is with their ego. But unconsciously we tend to identify also with the patient's super-ego and id, and thereby with him, in any prohibition on getting well, and in his wish to stay ill and dependent, and by so doing we may slow down his recovery. Unconsciously we may exploit a patient's illness for our own purposes, both libidinal and aggressive, and he will quickly respond to this.

A patient who has been in analysis for some considerable time has usually become his analyst's love object; he is the person to whom the analyst wishes to make reparation, and the reparative impulses, even when conscious, may through a partial repression come under the sway of the repetition compulsion, so that it becomes necessary to make that same patient well over and over again, *which in effect means making him ill over and over again in order to have him to make well* [italics mine—H.F.S.].

Rightly used, this repetitive process may be progressive, and the 'making ill' then takes the necessary and effective form of opening up anxieties which can be interpreted and worked through. But this implies a degree of unconscious willingness on the part of the analyst to allow his patient to get well, to become independent and to leave him. . . .

In my (1955) own experience, by contrast to that of Reichard & Tillman (1950), Lidz & Lidz (1952), Limentani (1956), and many other writers, I find that what the therapist offers the patient which is new and therapeutic, in this regard, is not an *avoidance* of the development of symbiotic, reciprocal dependency upon the patient, but rather an *acceptance* of this—an acceptance of the fact that the patient has come to mean a great deal, personally, to him. It is this acceptance of one's own dependency upon him that the mother had not been able to offer him.

I believe that in the great majority of instances where a patient and therapist have worked together for a long enough time for this symbiotic relatedness to become well established, and where we find that both are feeling hopeless about the work, we can find much evidence that each is unconsciously struggling to drive—or perhaps, more accurately, to keep—the other person crazy, so that he can cling to this highly immature and therefore 'sick', but deeply gratifying, symbiotic mode of relatedness with the other.

It may well be that the widespread need—widespread not only among schizophrenic patients but among, also, the professional persons who treat them—to deny the gratifying aspect of the symbiotic relatedness, accounts for some of the persistent viability of the irrational, name-calling 'schizophrenogenic mother' concept. That is, it may be that we are so powerfully drawn, at an unconscious level, toward the gratifications which such a mother offers, with her symbiotic mode of relatedness, that we have to deny our regressive urges in that direction, and this consciously perceive, and in scientific writings describe, her as a quite totally unappealing 'schizo-

phrenogenic mother' with whom it would be pure hell to relate oneself closely.

(4) So many therapists' and analysts' personally characteristic ways of responding to patients' communications sound, not infrequently, as if calculated to drive the patient crazy (or crazier), that it is difficult to attribute this phenomenon entirely to lack of clinical experience, skill, and perceptivity. That is, I surmise that many instances of awkward therapeutic technique, technique which fosters further disintegration rather than integration in the patient, may be due to chronically repressed (and therefore chronically present) desires in the therapist to drive the other person crazy.

As one frequently encountered example, we therapists have a strong tendency to react to only one side of a patient's ambivalent feelings. Thus when a hospitalized schizophrenic patient, for instance, is evidencing grossly disturbed behaviour such that we are given to know that he has an unconscious need for the security of continued hospitalization, but he is *consciously* expressing to us a strong, verbalized demand that he be allowed to move out, we may reply, 'I realize that you *really want to stay* in the hospital, and are *afraid of moving out*,' in a reassuring tone. This example involves a crudity of therapist-technique which one does not encounter with extreme frequency in quite so stark a form, although I have observed, not uncommonly—and retrospectively have realized that I was using in my own work with patients—just as crudely untherapeutic a technique as this. But lesser degrees of this kind of untherapeutic therapist-participation (throughout this paper, the points made are considered as applying in psychoanalysis as well as in psychotherapy, although with especial prominence in the latter) are observable with very great frequency indeed. Surely many a neurotic patient in analysis, for example, finds himself maddened on frequent occasions by his analyst's readiness to discount the significance of the patient's conscious feelings and attitudes and to react to pre-conscious or unconscious communications as

though these emanated from the only 'real' and 'genuine' desires and attitudes.

The therapist's or analyst's growing out of such ways of responding is not simply a matter of his learning a technique more appropriate to the patient's genuinely ambivalent, poorly integrated state. To become more useful to his patients he must in addition be prepared to face his own conflict between desires to help the patient to become better integrated (that is, more mature and healthy) and desires, on the other hand, to hold on to the patient, or even to destroy him, through fostering a perpetuation or worsening of the illness, the state of poor integration. Only this kind of personal awareness prepares him for being of maximal use to patients—above all, to schizophrenic and borderline-schizophrenic patients—and,

particularly, for helping them through the crucial phase of the transference which I have been describing in this paper.

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