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Negative Transference in Psychosis

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I choose the phrasing, negative transference, although it is not considered entirely descriptive by many writers. John Rosen [1] has said that the literature does not clearly define transference, and that there is no negative or positive transference, just transference. To Rosen, a patient expressing negative feelings is still expressing a need: "I see this patient as an angry baby, who, because he is not getting his way, or for other reasons, refuses to comply with his mother's wishes." I hope, within this paper, to clarify the meaning of these negative, hostile remarks expressed by patients during the heat of treatment of the psychosis.

As I have mentioned in one of my earlier papers, the psychotic is not a baby. [6] Remnants of regression to the oral period (neo-natal life) remain in all cases of psychosis. However, here is where the similarity stops and the differences become all important. The psychotic patient has experienced feelings of the oedipal struggle and has withdrawn away from it. In all the cases that I have treated, it has been the failure to find a solution to the oedipal situation and failure to find a self solid identity, that have caused a regression to psychosis. The treatment will be unsuccessful unless the patient emerges with a good solid understanding of what he is and who he is. To reach this feeling of self, there must exist a *negative* transference. *Negative transference is the knife that severs the umbilical cord.* Without it emerging in open battle between patient and therapist, there is always the danger of re-regression.

The negative remarks must constitute an explosive emotion directed at the therapist himself. If the patient's remarks are vague and disconnected, as in deep hallucinatory psychosis, there is little transference value. For instance, a paranoid patient may say "men

are following me," and have an elaborate system of persecution. It is difficult to pin such a patient down to facts. This circumvention we know is one of the cardinal symptoms of psychosis. Here there exists no negative transference toward the therapist as a being. Rosen **10** goes to great pains to have his patients include him in the hallucinations and delusions. I do likewise, even though in my experience patients will continue to see the therapist as benevolent and loving, and be passive toward him, as long as they need his support for strength. The strength they need is a strength to again be able to face their unresolved oedipal struggle with its castration and incestuous implications. This passivity continues even in the face of violent attacks at the psychotic system.

When the patient has become well enough, and the tables turn, it can be quite shocking to a therapist beginning work with psychosis, to feel the devastating direct verbal blows he is countered with. He can have spent several months or even years in bringing the patient from the depths of catatonic psychosis, and as is human nature, he will probably let down his analytic guard. Therapy now seems to be mere coasting compared to the steady and tedious psychological infighting that has occurred previously. Then the deluge begins. The therapist is accused of being a fraud, being sloppy, a cheat, a lecher, a persecutor, a jailor. (When asked why he shouted so, a patient answered, "I am only imitating you.") The patient should not be abandoned at this point because no identification of self has yet emerged. The patient is not ready to be on his own. Such abandonment might mean re-regression.

In desperation the therapist may search the literature for something or someone who has had previous experience with similar situations. I can tell you, such a search will be fruitless. As an example, Freud **3** states, "where the capacity to transfer feelings has come to be of an essentially negotive order, as with paranoids, the possibility of influence and a cure ceases." My experience has been otherwise.

The first case that I brought up to this point in treatment was S.L., a thirty-two year old Jewish, single male, college graduate, who had come to me from an established mental institution in Philadelphia. His treatment had previously included seven years of outpatient psychoanalysis. While in treatment at that time, the patient began to hallucinate that he and the therapist were secret agents

for the State of Israel. He became quite upset. His analyst gave up the case at this point and had him hospitalized. This was the patient's first experience with psychosis. I would call this a transference psychosis because the patient included his therapist in his delusional system. The prognosis in such cases is not hopeless. The patient got no better and was transferred to another institution where he was given sixty coma hours of insulin treatment. When I received him in my unit, two years later, he was still hallucinating and had gained a hundred pounds after the insulin treatment. In five months, with direct analytic treatment, he lost eighty pounds and was in a phallic aggressive stage of psycho-sexual development. He enrolled in school and began studying for his Master's degrees in education. He averaged 'B' grades the first semester. Soon after the start of the second semester, however, he told me that the professor was preaching Americanism and that he couldn't tolerate it. He felt that the professor was trying to influence his mind and the professor's views would not fit into his ideas of world union. The patient lapsed into deep psychosis and accused me of giving him nightmarish ideas. He talked out loud to a light bulb, that to him represented a microphone, saying I was a kike, a homosexual, and that if it took fifty years, he would get even with me. He was unable to sleep and talked and walked all night making speeches. He said he was Attila the Hun, and that his mother had seduced him and then cut his penis off. In a saner moment he said I was the one who wanted him to be a teacher and that I should have let him go to Israel and join the Israeli army.

This case shows a patient with hostile negative feelings toward me within the framework of psychosis. It also shows a struggle within him, between his compliance to what he felt was my wish, that he be a teacher, and his own desires for expression of self, shown in his wish to go to Israel. One can also see that to this patient, the loss of penis meant the loss of identity. There is no doubt that the "transference psychosis" was defensive, a protective resistance that developed as a result of therapy. Unfortunately, the boy was removed from treatment after five months because of finances, but when he went back to the institution he stopped hallucinating. His doctor told me that he noticed a big improvement since he had seen the patient, five months earlier. Apparently the boy had maintained his therapeutic level after leaving me.

In the cases that I have treated successfully through this period of psychosexual development, I am impressed by several things. Firstly, as I see it, there is a formula, (N.T.) × E = S, where

E = Energy available that has been bound by castration and incestuous fears.

N.T. = Negative transference

S=Self

This formula expresses the dynamic personality changes that occur when the energy bound by castration and incestuous fears is activated by negative transference. A stronger identity of self always emerges in a direct proportion to this negative transference.

Secondly the patient, through therapy, gains strength. He no longer needs his dependency; he severs the umbilical cord. To do this, the patient must be strong enough to take the risk of no longer having the same nourishing, protective relationship in which he is dependent on the therapist and to tolerate the unconscious threat of castration. He then begins to thinks of himself as a person. The patient who previously used the second person "you" to describe himself, symbolizing the union of the therapist and patient, now begins to use the word "I." This situation reminds me of the Hungarian people and their recent rebellion. It was only when the crushing effects of Stalin were removed, and the people had more food and greater freedom of movement as well, that they were able to rebel against their oppression.

Thirdly, negative transference is a defense against attack. Melanie Klein sees gratification and love by the infant directed toward the good breast. **4** Destructive impulses, feelings of persecution and frustration are expressions toward the bad breast. Anna Freud says negative feelings result when a patient has feelings of being engulfed or invaded by the analyst. In my experience this is true. All of the psychotics who have recovered and remained well, were able to fight with me openly and overcome their fear of being destroyed. They were able to see that the relationship with me was a symbolic one, and they really were not under attack and needn't fear me as a therapist.

The clinical examples which follow illustrate how the energy made available in explosive negative transference became available for greater ego growth.

One paranoic schizophrenic girl in this stage of treatment expressed

pressed herself in this way. “Direct analysis was wonderful when I needed pasting together. Now that I am an integrated person, I feel that you are trying to suffocate me again.” In more anger, she said, “You are a quack, I am going to a classical analyst!” She lived in a midwestern city and I sent her to an analyst who was recommended to me as excellent in working with psychotics. Apparently he sided with her feelings toward direct analysis and did not recognize her need to verbalize her negative transference. The patient was not helped and she had to return to work through her negative transference with me. When she returned she would get quite angry and say “after I see you I am good for several days. Then when I realize I have to live my own life, I get aggressive and masculine.” She was extremely ambivalant toward me, as all patients are at this stage. Her angry remarks were her way of separating herself from the previously dependent relationship with me.

Another patient, B.S., a thirty-four year old divorcee, well illustrates the ego strength gained by the patient through the successful management of the negative transference. The girl was a catatonic schizophrenic with over three years hospitalization and many electro-shock treatments. She was in active treatment with me for only a year and a half and was always in a home-like environment, never locked up. She was angry at every session and complained bitterly about being in the clutches of psychiatrists for the last five years. At this stage of treatment she was living independently in a hotel and had no psychiatric ties except for her visit three times weekly to my office. She made friends easily with men, but was extremely surly to older women and to me. Perhaps this gives us a clue as to where the feelings of negative transference arise with the mother. I asked why she was so hostile to me. “I have to protect myself!”

For two months her surliness continued and only when I brought her into contact with a third person, a young woman who had recently had a baby, did the hostility directed against me wane. The assistant spent several hours daily in her own home with the patient. The girl is now working, taking courses in the evening, and making rapid improvement socially. The sessions with me now are quite interesting. She had been mentally ill over ten years. She was totally unaware of current styles in clothes, politics and even music. She tells me her feelings are now like Sleeping Beauty, awakening

from a long sleep. She talks about herself in the first person, and calls me by name, something she never could do before.

The therapist's relationship with a psychotic personality must be as real as with children, and as symbolic as in the classical transference relationship with neurotics. This accounts for patients fighting with a therapist over unkept promises, like a child with a mother, as well as about things that can only have arisen from the patient's past.

During the heat of negative transference, the patient will not listen to interpretations about early infantile relationships. It never fails to amaze me how, early in treatment while the patient is more psychotic, direct interpretations seem to sink in. The therapist is elated at his abilities to make the correct interpretation each time. Perhaps half of the understanding has been due to the patient's hunger for a good human relationship. This is more important. If the therapy has supplied this healthy interpersonal relationship, the patient readily accepts the interpretations.

At the negative stage of treatment the patient is no longer interested in fighting with his own mother; the only person he now seeks out to fight is the therapist. This is probably because the patient feels more comfortable with the therapist than any other person, including his own family. All therapists have experienced the patient coming miles to see them, only to deliver a blistering attack. If the therapist has the fortitude to continue, he will be rewarded for his efforts. The patient does gain strength through this relationship. He will eventually understand that his fight was not really with the therapist, who after all, has only been in his life a relatively short time.

When the battle is over, the former psychotic is ready for what is perhaps the most practical part of treatment. Only now does the therapist see the huge gap that exists in the patient's personality. These people are really unprepared for everyday living. The energy that, for most people, is consumed in external social relationships as they grow up, is used by psychotics for inner defense.* The old psychotic superego structure now no longer exists. In many ways, the patient, for the first time, is ready to learn about life, much the

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* The psychotic is involved in his own intrapsychic relationship rather than an interpersonal one." Malone: "Concepts of Therapy with Schizophrenia." Lecture, Temple U. Med. School, Nov. 12, 1959.

same as a normal growing child in a normal environment. Elizabeth Geleerd writes about her treatment of adolescents. [5] The technique of my therapy with former psychotic patients is similar in many aspects to the treatment of adolescents.

It is very necessary to bring other people into the treatment. The patient needs to learn about everyday life. Friends of the same sex are encouraged and the patient is urged to take courses, join clubs, get some sort of work. All this minimizes the intensity of the transference* and helps the unconscious take its rightful place in the human personality. Patients, also need more privacy at this stage, to develop sublimations and phantasies. Perhaps this corresponds to the latency and adolescent periods, never experienced in growing up. At this time the therapist becomes somewhat of a stable image who is around, just in case. This is is a great period of "working through" that results in the developing of the continuously stronger ego.

The patients are constantly seeking parental substitutes to learn from, similar to the adolescent, who has rejected his own parent images, and form crushes on teachers, movie stars and athletes. They are very impressionable and frequently at this stage seem to always agree with the last person who spoke to them. The patient should now be guided with great care and should never feel that the therapist is controlling his actions or injecting moralistic judgment.

I am frequently asked whether it is necessary to analyze a psychotic after he has recovered from his psychosis. Rosen, in *Direct Analysis*, [10] has said he refers patients to classical analysts after recovery. However, he has recently told me that he now feels differently. He continues therapy himself in a semi-analytic, advisory manner. I feel that the therapy may still be called psychoanalysis, but the technique must be different. To place a psychotic patient on a couch for "free association" is most unrewarding. The threat of the turbulent unconscious is still present and the ego is not yet very strong. Besides, the resistances have been overcome by direct analysis during the treatment of the psychosis and therefore, couch techinque is both unfruitful and dangerous. Patients have told me

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* The patient must find some way to make peace with his or her castration and incestuous feelings. In latency, repression of sexual feelings occurs because of the castration threat mainly. In adolescence, the oedipal relationship becomes more genitalized, and the incestuous threat becomes the most important one. In psychosis, because the patient has traversed both developmental periods, the feelings may occur almost simultaneously.

that the distancing that occurs when they lie down or when I sit behind them causes frustration and anxiety that they cannot tolerate.

Anna Freud, in 1927, [9] said that "analysis of children has to be very different from the analysis of adults because of the immaturity of the child's ego and because of his dependency on the environment." Another reason for variation in therapy is that the child has just begun to develop a superego. He needs his parents and other adults to teach him what is right and wrong, and to guide him, so that in the long run he can make his own set of values and build a conscience. The analyst who enters the life of a child knows that, besides the analytic functions of interpretation and freeing the ego from too much invasion by the id and clearing the way for sublimation and maturation, he will also have the role of another adult in the child's life, who is expected at times to give direction and to support superego development. E. Geleerd [5] says that the adolescent is definitely in need of an adult friend, one whom he can trust, and can relate to, and can turn to in many crises. Very often he needs an adult just as a sounding board for the various ways of life he is trying out, in order to find the one that will be most fitting to him as an adult. He also needs the analyst as a superego figure. Since he has to reject his parental figures, it is essential for him to find a relationship in which he has sufficient trust and confidence to accept teaching of what is right and what is wrong.

A similarity also exists between the treatment of an adolescent and the final stages of work with a psychotic. The analyst cannot maintain absolute neutrality. He has to learn to introject himself without getting involved, frequently using himself as an example. He may vary this procedure with periods of analysis of the patient's daily behavior. He frequently has to extend himself as a companion or in a social way. I go fishing with patients, invite them to parties, and even help them find dates with members of the opposite sex.

The identity of self always brings up the question of cure. Unfortunately the determination of cure, or when a patient is cured, has not been given much emphasis in the treatment of mental illness. In his first interview with a prospective patient, Freud always asked two question: "Are you happy?" and "Do you enjoy your work?" Link [9] includes the ability to work, play, love and worship as essentials to a full life. Marie Jahoda [7] says that as far as we can discover there exists no psychologically meaningful, and—from the

point of view of research—operationally useful description of what is commonly understood to constitute mental health. Jahoda uses five possible criteria: (1) absence of mental disease, (2) normality of behavior, (3) adjustment to environment, (4) unity of personality, (5) correct perception of reality.

Certainly in a deep seated cure there must be a clear feeling of self. Patients who do not have this clear feeling of self are always vulnerable to re-regression into psychosis. Spock [12] thinks that an awareness of self becomes crystallized by the age of one year. The child indicates its separateness from the mother in terms that say, "I have wishes in regard to what I eat, to what I do, and my bowel movements." *Fremont-Smith [1] says the awareness of self begins with the infant's rage toward an outside object, in the early nursing period, at the inability to get milk from the nipple.*

It can be said that an awareness of self and a personal identity normally begin in infancy. The self then nourished and allowed to grow by an understanding and trustful relationship with another human being. How often I heard from my psychotic patients "this is what I believe, then after talking with my mother I question whether this is what I really believe; and then I think that I must be wrong—mother knows more about it than I do. I then become very frustrated and empty." Certainly any therapy directed toward more self-identification must have a clear emotional meaning to the patient. It is only through such a trustful relationship with another human being, with its full range of all emotion, that a healthy personality can emerge and continue to grow.

In closing, I would like to outline some of the important points:

(1) Psychosis is a result of the failure to find a solution to the oedipal situation and an identification of self.

(2) Negative transference is necessary for a person to find identification of self.

(3) There is a formula that can be applied (N.T.) x E = S.

(4) After sufficient expression of negative transference the battle quiets and the therapy can continue.

(5) Therapy of the recovered psychotic cannot be done with couch technique because of the peculiarities of ego structure. It is closer to the technique used with children and with teenagers.

(6) Normally, identification of self begins in the first year of

life and may first express itself in rage toward a milkless nipple.

(7) Any concept of cure must include a satisfactory identification of self.

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