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Negativism as a defence against symbiosis and its effects on countertransference - from the treatment of a schizoid adolescent girl

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For most of the presentation I shall portray the technical problems associated with the continuous refusal to speak spontaneously of this patient; even after five years of treatment this is still a major issue of our work.

A few weeks before I left for this trip she brought a few pages to the session which, as part of her evaluation of the present situation, contained the following poem by C. Zenetti:

we are talking	wir reden
we constantly talk	wir reden dauernd
	aneinander vorbei
we are talking	wir reden
	wir reden uns immer weiter
	auseinander
maybe we find ourselves	
by being silent	vielleicht schweigen wir
	uns wieder zusammen

Before giving you a short account of the patient's history and a short outline of the course of the treatment, I might remind you that speaking as a process of exchange has been made a cornerstone by Freud in one of his surprisingly simple sounding definitions of psychoanalytic treatment principles:

> Nothing takes place in a psychoanalytic treatment
> but an interchange of words between the patient and
> the analyst" (S.E. XV, p. 17)

This defintition does not specify who is supposed to do the talk, but from the context of this quotation we assume that this was regarded to be the patient's duty. The groundrule for the patient specifies the activity more as a verbalizing activity whereas the complementary groundrule for the analyst underlines his role of an active listener.

The "talking core" paradigm of psychoanalysis was questioned by Ferenczi's paper on "Confusion of tongues between adults and the child" (Sprachverwirrung zwischen den Erwachsenen und dem Kind) (1932). He doubted the suitability of the adult's language for the communication of a language of tenderness and passion which a child longs for. Ferenczi's technical experiments were designed to create a language suitable for this task, replacing words by gestures and other preverbal communications.

Ferenczi's ideas were further developed by Michael Balint, relating the function of language to the level of object relationship achieved. On the level of basic fault, the language has functionally regressed to the early state of maintaining contact, providing simple sensory stimulation. Masud Khan has given an impressive example for this phenomenon in his study "Silence as Communication" (1963): he describes an 18 year old boy who stopped talking after the first interviews. Khan describes very vividly six weeks with the patient coming once a week for psychoanalysis. Khan used his own countertransference reations as a material basis for his interventions. He took over the function of language for the speechless patient, and, in this way, bridged the gap in my relationship with this patient whom I now shall introduce in more detail.

In March 1977 an 18 year old girl was introduced to the outpatient clinic of our department of psychotherapy by the wife of the head of a boarding school in the neighbourhood of Ulm. The school has a special reputation for dealing with difficult pupils that are usually sent to this school due to problems in their home schools. The patient was seen by a social case worker who routinely takes a social history and by an experiences colleague who just come from Topeka to Ulm.

The girl complained about difficulties to concentrate on her work from the age of fifteen onwards. She had developed an increasing inhibition to write down anything at school. This along with grave social problems - fiercy debates with

the teacher over this embarrassing negativistic behavior caused her to fail the 12th grade. Her mother was involved in this struggles at school and decided it all being caused by a failure of the school; so the girl was sent away to this special boarding school without really consenting to it.

The new surrounding did not make a great change. For a while, the remarkable eloquence, of the intellectual aloof and cold kind, compensated for her inhibition to write; again, this disparity led soon to heavy emotional struggles with the head of the school and his wife. They at least understood, that the girl was acting out emotional problems. So sent her to a psychiatrist. They reported a very strong feeling to help this girl; however finally being left helpless as all efforts to help her would fail.

The physical apearance of the patient was quite strange: her face is roundish and baby-like, with not well fitting spectacles. Her body, though well developed, was hidden in peculiar garments, home-made and old-fashioned. Her gait reminded of a marionette moving like a ballet dancer. Her appearance was so remarkable that the head of the department made a diagnosis of schizophrenia just from the way she moved down the corridor - in splkendid isolation.riate diagnosis is not the focus of this presentation, I may comment that we never could settle this issue. She never mentioned any productive symptoms, she never showed any thought disturbances. Besides the clearcut writing inhibition which refered only to such writings that had importance to her career and the incapacity to read school-related material, to concentrate on this, there was a marked estrangement from herself, a feeling of being not really in full possession of her physical and psychic power in order to establish contact with anybody. If she would have fight someone, however, she was able to use her intellectual gifts in a very cold and penetrating way; there was not much left of this world which she would approve of.

At first only her school activities were involved by the process of inhibition; when she presented herself for the interview, we could find out that more or less all other significant activities like playing the guitar, singing, moving in the bllat lessons were blocked. A careful analysis of these inhibitions later showed that the degree of inhibition was directly related to the degree of personal importance. Her favorite subject, biology, a hobby of her for many years was the first one to become affected. She wanted to become a scientist in the field of

research on Stabheuschrecken and had already done some systematic observational work. Mathematics and physics followed closely. The languages were at least affected as she didn't care for them much. The amount of importance she attributed to a subject was also related to her estimation of the teacher of the particular subject. What she made suffer was failing especially there where she wanted to please. The inhibitions had a physical correlation; her muscular system showed the typical waxlike rigidity to be related to situations where one could assume that she felt torn. I could directly assess the outcome of the individual session by noting the way she left the room. After bad sessions she would stay for longtime in a waiting space outside my door, a living motionless complaint. Yet, it is just by the way she can walk out now, too, that my colleagues realize that things are getting better.

Some comments to her biography: She is the first child of parents that are both academically trained in natural sciences. The mother, a very active, dominating and overprotective woman gave up her own professional career when the unwanted child was born. It seems to me that the mother had better prospects for career success than the father, a rather shy and withdrawn person. As a chemist he is comfortable handling his inanimate substances, but he failed to establish a satisfying working situation for himself. He has been the head of a small laboratory that only does routine checks for the production of a chemical substance in a village in the north of Germany.

The family has elaborated a special myth to obscure the father's failure. The two children, my patient and a brother two years younger, were discouraged to mix with the other village kids, to avoid getting stuck and teared down by that milieu. The mother used to promise to the patient as a child: that when she got older and would go to the gymnasium in the city she would meet the right friends there. The patient never went to kindergarten, for the mother thought she could provide a much more stimulatingpreschool atmosphere. The brother of the patient turned out to be a hyperactive child: as a kind of punishment he was sent to the kindergarten, to calm down there.

The patient upon entering elementary school experienced very severe separation anxieties; she well remembers the mother's coldness and rejecting her now in public. The patient though well advanced intellectually felt to be an outsider at school right from the start which did not really change in the long run. At home

the mother would carefully watch her homework, explain it all again and even beat her, when the patient could not live up to mother's expectations. The patient remembers that she never really learned to work for her own; as she knew her mother would want to work with her, so why should she bother.

But besides this painful memories the patient reported very intensive experiences of a close relationship, of closeness without words. She subscribed the idea wholly that their family was something very special. Additionally mother and daughter suffered from the father's state of chronic depression framed in a despise of the world, of politics: only classical music and/or academic achievements really were worth to be strieved for. The mother emphasized the importance of the daughter to succeed and thus fulfil deep needs and wishes for both parents. The patient complained that with her father she only could argue; he would never show any sign of tenderness and love. It was the mother who told her how important she was to the father. She had to act on double load as it soon turned out that the brother was a failure in school. He became a lost case for the family's ideology of being something very special. When the patient was 12 years old, he was sent to a boarding school far off the village. It took quite a while in the treatment before the patient would reveal her loneliness; she herself needed the ideology of a special childhood and family life for defensive reasons.

Finally she remindes that at the age of seven her mother took her twice a week to a ballet school. She liked it, but was unable to contact any of the other girls as she knew that her mother would watch carefully. So birthday parties became the mother's occasion to ingeniously celebrate the family's social autonomy.

The patient's violin lessons triggered her first fight with her mother. The patient in the 10th grade, for the first time was part of a group with three other girls. Like the other three she wanted to drop the violin lessons and start the guitar. They had a student of music available to teach. The patient had long arguments with her mother who was very insulted that all her endeavours should lead to nothing but this rock business. The patient desparately tried to tell the mother that she wanted not to betray her, but just to add something new to her life: social relationships with peers. The mother used the fathers love of classicla music - she would understand it - to make her daughter feel guilty for giving up

the violin. The patient failed to achieve any significant comment from the father himself, again with the mother erecting a wall around him.

It was during this struggles that the patient started to have difficulties concentrating. This gradually led to a situation where the patient could either follow her newly developing interests, implying to cause a destruction of the family's happy altogetherness and thus loosening of the family bondage or fulfil the familiar expectations imposed on her. The inhibitions that spread throughout the patient's significant activities disposed her of the necessity to decide upon while leading to import self-destructive consequences. She would neither fulfil the expectations nor find a way to her own life. At the time of the first consultation she was about to drop out of the higher education system, having failed twice 12th grade.

I saw the patient for the first time in May 1977; the colleague who had first seen her for a few sessions left our department and asked me to continue the treatment. Within a few sessions I held with the patient I was just able to repeat the impressions of the colleague and experienced what other people before me had also described. This patient elicited a very strong feeling to rescue her. She was very quiet, motionless, answered questions as short as she could, but showed no initiative on her own. I felt overwhelmed after a while by this longing for activity, by this state of waiting for somebody to fetch her. "Waiting for Godot" - was one of the first associations I had. I doubted whether the proposed one hour weekly scheme would work with this patient. The conceptualizations of her problems as an adolescent protest reaction with a schizoid withdrawal as a focus one could profitably work on was swept away by a feeling that this girl needed a very intensive long term treatment in a hospital. I must admit that I was not prepared to fill the void I felt in these first sessions with her and so I managed to send her to a psychotherapeutic clinic for adolescents nearby Goettingen, which by the way was very close to her home village. The patient was not enthusiastic about, but finally consented. She must heve felt my resentment to take on her load. I did not pay attention to her weak efforts to advert another state of desertion.

The patient stayed for three month in this clinic; at the end of September I got a call from her asking me: would I take her back.

When she came to Ulm again she had settled realistically with her parents that she could stay without attending the school which she had to leave due to her failure. I arranged for her to live in a rehabilitation clinic for psychiatric patients which she accepted very unwillingly.

I saw her three times a week face to face and could successfully apply for an insurance coverage for 160 sessions with a diagnosis of neurotic crisis. A diagnosis of schizophrenia would have ruled out an insurance claim for psychotherapy. The parents were not prepared to pay for the treatment, as they objected it straight away. I could arrange to see them once, as they visited their daughter. So the treatment itself became a step away from the parents.

The patient never talked much in all these years. But in the first year she barely responded to me. She came regularly, never missed a session, was very affected by an absence on part of the therapist but did not show any incentive to speak on own initiative. From time to time she would call me in between the sessions during evenings, just telling me her name, then waiting, breathing very heavily - waiting that I would know what to say. I tried to bridge the gap and to reduce the tension for her and for me by talking about the things that came to my mind. I tried to elaborate the history further, to work out possible relationships between life history and symptom formation. From time to time I achieved that she would say: no, but without giving a positive formulation of her view on it. What I observed very strongly with myself was a great difficulty to keep track of what I had thought and interpreted. I had the very strong urge to write up the sessions, while afterwards the contents of them were quite nebulous. It was a conflict with the theme: touch me and toch me not.

After a year of this very hard and strenuous work she surprised me by saying that she hadn't heard me at all, that I was sitting too far away. I was really struck, being angry, hurt and yet grateful. Also being tired of a therapeutic situation where nothing seemed to move, I asked her what her proposition would be. She expressed the wish that I should sit close to her, side by side, not face to face with a table between us. When I tried to interpret to her that she had me set away as a reversion of my sending her away to the hospital, to make me feel what it means to be deserted, to be without reaction, the patient did not accept it. She said very outspoken that it would not be any help to her having me talken when I was so far away. Only that part of her that outside the consulting

room would still function would hear me. What she would need was that her other part, that she had lost herself, would hear and feel what I would say and do to her.

That was a very sensible statement which stirred up some discussion in our group. It clearly expressed the patient's need for my help to undue a split she could acknowledge for the first time. But she would not go for mere symbolic means. My reacion to this proposal was very ambivalent. I had the recurrent thought that if I were a woman I would have less difficulty responding to it. I could not figure out to what extent the patient, being physically so well developed, was aware of sexual feelings. As far as I could work out with her in this very one-sided dialogue of the first year, she had only recently - during her stay in the hospital - met a fifteen year old boy with whom she had spent some time listening to him playing the flute. Irrespectively of the symbolic of it, she had enjoyed the feeling of being attractive to this boy, but she felt she could not expect more from him than that, as he was as much inhibited as she herself was. What she longed for, so it seemed to me, was to meet a man who would face her closeness as contrasting her experience with the withdrawn father.

My reaction of thinking if I were a woman I would be less refrained from giving her this closeness was just what the patient did not want. The pattern that she was picked up by a woman but left alone by a fatherly figure had also repeated at the boarding school, where the wife of the headmaster had engaged herself so much for the patient. In the year the patient had now spent in Ulm, staying at the rehabilitation center, she was reported to be a very demanding person, easily disappointed when the male psychologist who runs the house would not spent as much time as she wanted with her, and then she would withdraw in a cold, rejecting autonomy. The letter from the hospital where I had sent her to, basically reported the same development. The patient had left the hospital as there were only stupid doctors, incapable of doing their job properly, only interested in having much spare time, but not really interested in their patients, trying to push the nurses to do the psychotherapy work instead.

Though all this material did make sense to me and was tried for an interpretation of her wish that I should sit close to her instead just so far away, it did not change. That part of her that I call negativistic - where she would be very strong and outspoken - responded to all verbal interventions with plain "no" or

"useless" or "this may make sense to you but not to me". That part of her I could communicate with this kind of verbal exchange had failed in this world. She was trying to convince me that what she needed was a real measure, real action taken by me, not just a surrogate. On top of it she needed an extraordinary patience to face her destructive tendencies against the measures taken in favor of her.

As the story of her school record already had shown,she achieved to interest teachers for her special situation, but finally spread despair onto their efforts. I was about to experience the same lot. That statement after just one year of work with her nearly silent, just mumbling a few forced answers, but being present day and night, really did not contribute to enhance my motivation. Similar experiences happened with other peoples I had arranged her to work with. So she had a private teaching for some of her subjects, just to remain in some contact with school work. Within few months the teachers gave up; they regularly ended up disputing heavily with the patient about some minor detail, which to her was always of very great importance.

With this first crisis in our work the bridging function of speech was questioned, and as I have quoted by the poem is still questioned.

At that time we worked on the problem for quite a while. I was not prepared - again I was not prepared - to give in. From my other clinical work I was convinced that direct gratifications as a rule don't really solve the problem. As this was my first case of intensive treatment of an schizophrenic patient, I was particularly determinded by the conception that on theoretical ground so great a closeness could not be very sensible. The patient, however, insisted on her wish that she would want me to sit closer to her. For quite a while I tried to translate this closeness into verbal operations that she wished more accurate closeness in my knowledge about her present life. This again didn't work. - She even avoided to let me participate on her daily activities. We had arranged for her to work in the hospital as an laboratory aid, where she could use her abilities and have some social contact. But I never succeeded to get a detailed picture from her.

It was only lately that I realized and could agree with her on that she needed this segregation of her everyday life from me. Being totally supervised by her mother - day and night - she had developed the technic as a school kid to keep a

book in the drawer which she would read while pretending to work to the mother. As soon as the mother would turn up she would simulate to be in sore need of mother's help. But she had never dared to disentangle her from the mother's world directly and openly. All my asking for history, everyday life etc. to her meant the same kind of intrusion as the mother's unending curiosity was.

So speaking to the patient meant for her being kept in the mother's web; silence was a state the mother could not endure, thus suffering terribly from the father's withdrawn states. "Even when we all were hiking in the mountains, mother never really could stop herself talking instead of looking at nature's bauty."

With all this work of understanding the different meanings of silence and speech the second year of our joint effort passed by. I had not changed the position in the treatment; the result being the continuation of the very painful and strenuous therapy. I started to doubt my qualities as therapist for this kind of patient; I ever so often considered to end the treatment. It was an "etat de siege" of a fortress. One of the metaphors that helped me in these phase of the treatment was the fairy tale of "sleeping beauty". The idea that the patient went asleep with the onset of sexual feeling, as it would mean to leave the parents, and this would mean killing them both, helped me to organize the development. It was also helped to understand my frustrane efforts to overcome the thicket that encircled the castle. It was the thought that one day a young prince would turn up, when hundred years have gone by.

The patient repeated her wish from time to time that I might sit closer to her. Lack of closeness becomes the common denominator wgere I can try to show to her that in all relationships except the one with the mothershe is complaining of it. And the one with the mother is much to close, there is not enough autonomous regulation of distance and closeness with the patients need. The question of her autonomous regulation came back to her question of closeness in the therapy. Pointing out that she could make a decision, too, one day in the third year, the patient took her chair and placed ist besides me. It was obvious that this step was very painful to her in a concrete bodily sense; she moved very awkward and was very stiff when sitting beside me. I interpreted to her that now she would not know what was going to happen, having no real experience of intruding the intimate space of a male person. Her father would have reacted to such moves by sheer denial, not showing any sign of approval. The only way to

converse with him were very loud politic debates, where they would violently wrestle. My comment pointed out that there was no danger of too much closeness when conversing on controversial topics.

With these moves the patient also had begun to change her way of clothing. The dresses became slightly more attuned to the peers, though she maintained that blue jeans were not her concern.

She started to complain that she could not find friends as all the young people would only enjoy disco music. A struggle between us in which the patient again insisted on me showing and introducing her to the kind of young people with serious interests in music. I chose a middle way. Making definte proposals like the students choir of the university or ballet course, I insisted that there must be at least some specimen of man that would be alike her if she only would be involved in locating them. It was somehow a repetition of the question of sitting besides me, which continuously did.

A major step in the third year consisted of the gradually informing me that she would want to stay in Ulm, never return home again. It implied as I could understand the idea of giving up a hope for immediate reconciliation with the parents and creating a situation of adoption. Would I keep her, would I step into the parenting task. This involved quite realistic decisions whether I would be prepared to accept a no-fee treatment for her. The insurance coverage had run out and there was no other way of finding a way to cover the fees. The parents would openly reject the notion of paying for the treatment, considering the whole development of her getting independent as a direct hostility against themselves. The decision somehow was to be made: shall I take her on, shall I adopt her in a very concrete sense? I remember a continuous line of countertransference feeling of not being prepared to meet her demands. This feeling runs through all the time like a red thread. After quite a few consultations with colleagues on the topic, I decided for myself to meet the expectation working on the "waiting for Godot" phantasy, on the theme of rescue out of an enmeshment in contradictory expectations. I would like to learn your opinion about this aspects of feeling to be much more factually involved in such kind of treatment, where not only symbolic significance is sought out, but where a patient claims a real need for new, less ambiguous experiences.

In this situation we settled a new scheme. The patient could tell me that she would prefer to come more often, would want to have a daily contact I could respond to this wish, having decided for myself to try this kind of encounter the distinct notion that the patient had settled in Ulm, under a kind of patronage, as I would call.

Interestingly enough, the patient had experienced a similar disappointment of her expectations in the rehabilitation clinic and had moved out into a single room appartment. During this period in the third year, she was very dependent on my availability which involved quite a few telephone calls in evenings and weekends that I had to go through. She acted out the patronage fairly strong, and I experienced ever so often a feeling of bitterness and anger why I had to go through all that. Trying to read the patient's behavior in terms of a child's expectation to dispose of a holding environment helped me to overcome the aggressive counter reactions to the patient's symbiotic demands.

The situation in the sessions did not change much. The patient came punctually and regularly, never missed a session, but never started a sentence by her own.

As this behavior is most central to the treatment still now, I would like to focus very precisely onto it now: The patient waits outside, and when I come to fetch her she rushes in, she does not greet me, and my saying helle or even efforts at the beginning to make shake hands were only passively responded to. Finally we found out that to her all the events outside the consulting room, the social frame belonged to that part of her which was cold, inanimate, which had no significance to her. Upon entering my room, she seizes her chair and places it close to my chair, sits down and is waiting. She waits for ever so long, her inner situation however deteriorating very soon when I do not begin talking. When I am angry, thinking that she could do as well than me just help me where she would be, the patient after a few minutes, five or so, becomes stiff and distant, just withdrawing, with an obvious increase in breathing and with red spots all over her face. Sometimes when I then start talking it is just too late, I cannot reach her any more, and the session will be characterized by very strenuous efforts of my side to "understand" and by desperate, very silent efforts of the patient to be found. The silence of the patient is a verbal silence with very few spontaneous talk. She would respond to a question, but she would not elaborate on it. There is no spontaneous dialogue going on, on the verbal level. On the

averbal level, her way of communication would be characterized by a rigidity of her hands: they become very twisted, both hands, and when I try to point this out she is looking at me with a mild gaze of despair. I feel that she would say: How do you expect me to be changed by words, just hold my hands, and I will be consoled. This is my very clear feeling in this reactions that the bridging function of the words is lost altogether. I just try to talk. Sessions of this kind will end without any other work done but just my effort to understand why things have gone wrong again.

This pattern is very typical of Monday sessions, where I can never give up the idea that it would help me to learn how she has spent the weekend. The patient constantly refuses this, and we are ending up in this mess. Tuesday session will be a session of mourning, where I find myself terrible that it all went wrong, and it is on Wednesday that I can settle down, having no expectations and just trying to communicate to her what I can think of.

To give the reverse picture to you of what the patient considers a good session: Following her wishes the best would be to share my real life experience with her. She would want me to tell her about books I have read, to tell her of games I like to play, to share my view of Kafka with her, to give one example we recently had.
She maintains that she suffers a lack from intellectual and emotional feeding. And here the critical issues for me are involve. This girl is very intelligent, has read a lot, has been a good pupil in school, does not convince me of having deficit in intellectual food. I tell her that my view would be that she wants some other kind of food, new kind with less restrictions than the kind she got fom home. My withholding this kind of information would be rationalized that I do not want to confirm her idea that she has never had good feeding. To this idea the patient cannot subscribe at all. At this point in a session she can become quite talkactive, saying with very pronounced, hostile undertone that I just have to stick to my theories, that I do not trust her that she knows better. We are ending up in a political fight, so to speak, as it used to be with her father. Pointing out this transference repetition makes her angry, now accusing me that this kind of dragging past into presence makes things for her even more difficult to handle. The results of such sessions could be that she stays at home the whole day, cannot go out for any contact, and would phone me up in the evening, feeling very hopeless and despaired.

My dilemma, the doctor's dilemma so to speak, is that the patient's treatment philosophy does not match with my philosophy.

But as she tries to show me, her philosophy works. Whenever I followed the patient's line of letting her share my life, she could make use of it.

What she wants of me she can point out very clearly; talking to her mostly implies distancing, she does not belief in the carrying function of words. She does belief, however, and very strongly , in the carrying function of action.

In the fourth year, I was able to understand her wish to go back to school with me fatherly stepping besides, looking at it as part of my pride. So I did. To make it short, in these last two years she repeated the 11th grade, finally mastered in the 12th grade with high success in her favorite subjects, but with an continuous struggle for my direct support. She is now applying to the university for a biology grant; there are two professors highly interested in her.

The therapy continues along the lines I have described. In the last six months she would bring a toy along with her, expecting me to hold it. I suppose all my talking is very useless, except that it keeps our relationship at a disappointing level which allows for a deeper, continuously growing symbiosis.

I am impressed by the change the patient was able to initiate in school, but I am at the same time horrified by the amount of loneliness that there still is. I suppose my functions for this girl's further development have not yet come to an end, but I certainly would wish I could enjoy the daily work with her as much as I can now enjoy her being back to a way she once had to leave, when five years ago she did not know how to find her way out of parental bonding.