einer tragenden Gemeinde oder von stabilen Familienverhältnissen aufgefangen werden. Um den Betroffenen eine gewisse Lebensbasis zu bieten, sind vielmehr dezentrale entwicklungsfördernde Institutionen und soziale Netzwerke neu zu schaffen. Das ist aber leichter gesagt als getan. Denn der Kostendruck in einer auf kurzfristigen Erfolg angelegten Gesellschaft lässt zwar eine zeitlich limitierte Akutbehandlung zu, erschwert aber den Aufbau langfristig enorm wichtiger Behandlungs- und Betreuungsnetze. Zwar darf auch in Zukunft mit engagierten Personen, Familien und Trägervereinen gerechnet werden. Aber diese einzelnen Hilfestellungen benötigen die Unterstützung einer leicht erreichbaren und anhaltend kooperativen institutionellen Psychiatrie.

Je mehr die soziale Desintegration fortschreitet, desto wichtiger wird es für psychisch Kranke und Angehörige, dass sich die Psychiatrie wieder auf den Wert der Gemeinschaft besinnt und beziehungsorientiert denkt und arbeitet. Dazu ist es auch nötig, eine Sprache zu finden, die nicht nur von Funktionsstörungen des Gehirns handelt, sondern auch das seelische Erleben der Betroffenen (und Mitbetroffenen) und ihre Beziehungssituation mitbeinhaltet. Ich glaube nicht, dass die Psychiatrie diese grosse Aufgabe allein bewältigen kann. Sie braucht die Hilfe von aussen, von psychisch Kranken, von Angehörigen und von engagierten öffentlich und privat tätigen Personen, welche die personalen Bedürfnisse der betroffenen Menschen wieder in den Vordergrund rücken.

# "Transitional subject" in two cases of psychotherapy of schizophrenia[1]

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**Summary**

The psychotherapeutic approach to schizophrenia in this article is based on the theories of Benedetti. The attempted psychotherapy is paying particular attention to transitivism and appersonation as well as to the key experience of the transitional subject that develops in communicative psychopathology.

*Keywords: Bleuler school; schizophrenia; transitional subject; communicative psychopathology*

## Introduction

My direct contact with the theories of schizophrenia of the Bleuler school began when I found a thesis coauthored by Scharfetter and Benedetti [1] in the Schweizer Archiv für Neurologie, Neurochirurgie und Psychiatrie, while I visited Burghölzli during the wintersemester of 1980. I have since introduced to Japan the theories of the Bleuler school concerning schizophrenia, which were scarcely known in Japan at that time. For 20 years, I have considered this a mission in my life [2–4].

Psychopathology in Japan, which had historically been strongly influenced by German medicine, particularly the Heidelberg school, has had a speculative and philosophical inclination and been particularly indifferent to therapeutic approaches to schizophrenia. I was attracted to the Bleuler school because its approach to psychopathology was consistently linked to therapeutics. The present decline in interest in psychotherapeutic approaches in research on schizophrenia in Japan is regrettable and may be a global tendency. Should we idly overlook this situation, knowing that it is never to the advantage of the patients?

According to Benedetti [5], the psychotherapy for schizophrenia is not one of various psychotherapies. Patients are spokespersons of its existence, and healthy individuals experience the human situation more deeply through basic forms of pathological *"conditio humana"* in patients. Psychotherapy for schizophrenia does not stand on the same plane as biological psychiatry nor is it affected by progress in the latter. Here, I would like to describe Benedetti's concept of transitional subject and emphasise the effectiveness of his psychotherapeutic approach to schizophrenia.

## Benedetti's theories

Benedetti [6] attempts to bring about the split world of schizophrenia in a dialogical relationship by personally involving the split rather than objectively viewing the symptoms of splitting. He always affirms psychopathic experience, enters the morbid world, and tries to understand its symbols. A kind of communicative psychopathology is thus developed. What cannot be directly understood by reason becomes comprehensible through appersonation and transitivism, and the nonsymmetry between patient and physician is sublated in the experience of duality. Whether one has a psychotherapeutic attitude or not is equivalent to whether one is ready to convert transitivism and appersonation, which Bleuler described as classic psychopathic symptoms, into archaic communication forms through one's own fantasy and association or not.

Benedetti [7, 8] called the psychopathology in which the patient's autism becomes autism of the patient and the therapist and progresses to generation of the self "progressive psychopathology". The transitional subject emerges in this psychopathology, and it bears the development of the dialogical space of dualised psychopathy. The transitional subject is something that may be called a "phantasmic subject". It is not the same as the personality of the therapist or the patient but emerges from both. It springs from appersonation and transitivism. By the terms of psychological mechanisms, it arises from transference and countertransference, from identification and counteridentification, and from introjection and projection.

## Case reports

The first case is a woman in her mid-thirties. After the onset in adolescence, she maintained an autistic attitude, exhibited strong negativism over a prolonged period, and was extremely difficult to make contact with. She manifested emotions only when she was affected by morbid experiences. There had not been any changes noted over more than 10 years despite various medications. The therapy began as the therapist handed her a cute doll about 40 cm long. We decided to use the doll because a doll was used in the report by Sechehaye [9] and because we attempted to become more closely involved in the morbid world of the patient by using the doll, which is a typical example of Winnicott's transitional object [10].

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1 This is a digest of the chairman's lecture given at the 21st Annual Meeting of the Japanese Society of Psychopathology held in Osaka in September, 1998. The full text of the lecture was published in the Japanese Journal of Psychopathology 1998;19:223–32.

She received the doll, saying, "What a cute doll!" and shortly gave the doll the name "T". Her examination was conducted using this doll as a medium. First, the therapist simply praised the cuteness of the doll held by the patient and her manner of lovingly holding the doll. Then, the therapist shook hands with the doll that the patient was holding. He greeted the doll. Depending on her mood, the patient returned the greeting by having the doll nod. If the patient did not refuse, the therapist took the doll from her hands and held it himself and touched the patient's hand with the doll's hand. Over time, the patient began to refuse less frequently than before.

One time, the patient began to cry bitterly and would not stop crying. "Who is crying?" "It's me." "How about T?" "Oh, T may cry, too, at times." The patient blinked for a moment looking puzzled, but she then shouted, "Oh, T began to cry," and the patient did not cry any longer. The act of crying was transferred to the doll, in an act of transitivism. Another time, the patient was gazing at the doll without an expression. So, the therapist said, "Is T crying?", and all of a sudden, the patient began to cry loud. The experience that had been transferred to the doll returned to the patient's mind. She soon stopped crying and talked to the doll, gazing at it, "You don't have to cry any more." Such a process was repeated many times.

After about half a year, the patient, looking pale and holding the doll, came into the examination room with unsteady steps. She said that T ate all the food for the patients so that they all became skeletons. The doll had become equal to the patient's personality. The patient said, "When T becomes hungry, she taps her abdomen and says 'Give me a piece of biscuit.'" Of course, it was the patient that was hungry. She said there was a piece of biscuit in the doll's pocket, but, actually, there was only a piece of paper folded into a small lump. The therapist, however, replied, "That's right, there is a biscuit in the pocket," completely sympathising with the world of the patient's experience. The patient smiled and offered him the biscuit. The therapist mirrored the patient's happy mood, and they had a lively conversation. Such a phenomenon is neither an actual event nor a phenomenon in the patient's solitary autistic world; it may be regarded as a psychopathic fact established between the therapist and the patient. Benedetti called it the third reality.

Nighttime excitation gradually subsided, because T stood sentinel over the bed through the night so that no one would do any harm to the patient. The patient could sleep soundly, because the part of the patient's personality that was involved with the delusion of persecution was transferred to the doll. At one time, the idea of suicide cherished by the patient was transferred to the doll, and the patient told me that T attempted suicide many times. The therapist positively asserted that there was no need to commit suicide by gently touching the doll but turning his attention to the patient.

One time, the patient visited the examination room alone, saying that T was crying in bed. The therapist immediately let the patient bring the doll. Back in the examination room, she fondly gazed at the feet of the doll and murmured, "How cute they are! There was a time for me, too, when I had such small feet, wasn't there." She gazed at the doll to which part of her own personality was transferred and remembered her younger days by assimilating herself to the doll. Around the time of this incident, the patient dropped the doll on the floor during conversation. Unfortunately, the head of the doll hit a corner of the desk in the examination room. The patient instantly gave a loud cry, "Ouch!" At this moment, it was the patient herself that was dropped to the floor, but she then carefully picked up the doll and soothed it repeatedly saying, "I am sorry, it must have hurt." It was a scene reminiscent of a mother with her baby child.

After about a year, the patient began to recognise the therapist as her beloved uncle although he always wore a white coat with a name plate on the chest. Shortly after this, when the therapist was talking to the patient holding the doll on his lap, she brought the fingers of the doll to her lips, saying, "Let me smack you, let me smack." The patient was moving her lips as if she had food in her mouth with eyes closed and looking ecstatic. This was what Winnicott [10] described as a transitional phenomenon. The finger of the doll held by the therapist transformed to the nipple.

Around this time, the patient began to frequently talk about babies. Her crying also came to resemble that of a baby. "I am only a baby who has matured." When the therapist handed the doll to her, she hugged it tightly and rubbed her cheek against it. She would sit face to face with the doll and repeat the game of "peek-a-boo" many times. She was in the world of infantile solitary play.

Also around this time, the patient reported a horrifying dream of flying about roaring in a strange place. It appeared to symbolise the primitive agony of the patient, which Winnicott described. Shortly after this event, when the therapist was talking to the patient, while holding the patient's doll on the lap, the patient shouted, "You gave birth to T, didn't you!" In the imagination of the patient, the therapist became the doll's mother. Thus, he became the patient's mother via the doll, to which the patient had transferred her own personality. Then, instead of trying to kiss the doll's fingers, she moved her lips, saying, "Mom, Mom, Mom, smack, smack, smack" and actually kissed the therapist's cheek. In the patient's imagination, the therapist transformed from her uncle to her mother. The therapist himself changed to a transitional object.

The next case was a 30-year-old man. He had remained autistic and shown a rejective attitude for many years and had complained of diverse hallucinations and delusions. After more than a year, the patient recovered to a state that he could go walking with the therapist. When the therapist tried to straighten the necktie during the walk, the patient stopped in the middle of the road, saying, "I am the mirror," and posed as a mirror. The patient tried to reflect the entire personality of the therapist. The therapist had already been drawn into the third reality.

Then, the therapist had the patient sketch the therapist at each interview using coloured pencils. There was no difficulty in persuading the patient to do so as was expected from the above episode. He would sketch the therapist, saying, "You are good-looking, doctor," and "You have excellent taste in choosing your ties," and finish the drawing in a few minutes. Since the patient paid particular attention to the necktie, which highlighted the therapist's self-image, the therapist changed the design of the tie every time. In a few months, the contents of the sketches began to change. The necktie became less distinct, and the sketched face of the therapist came to resemble that of the patient. The white coat of the therapist was drawn with the design of the clothes of the patient. Eventually, the contour of the figure drawn also changed, and the white coat was completely replaced by the patient's own clothes. A new self-portrait was created through appersonation and transitivism. The patient liked weekly cartoon magazines. When the therapist had the patient sketch the therapist by concealing the necktie with a cartoon magazine to promote appersonation and transitivism, he readily drew portraits in which the patient himself was fused with the therapist.

## Discussion

The interaction between patient and therapist developed in the third reality, in which appersonation and transitivism are mixed. Benedetti [7, 8] identified what may be called autonomic psychic reality, which emerges from the tension between symmetry and asymmetry that lies between therapist and patient, belongs to neither of the personalities, but mediates them, a transitional subject. It may also be called a phantasmic subject, which reflects a new self-portrait in the mind of the patient like a mirror in the common therapeutic unconscious due to positive ideas of the therapist and serves as matrix of the self. Such a transitional subject was embodied in the approach using the doll.

There is a close relationship between the concept of transitional subject of Benedetti and the concept of transitional object of Winnicott. In the female patient, the therapist was not simply a representative of the reality but acquired the possibility of transforming reality and eventually became a transitional subject himself. The interchange between the infant and the mother progressed markedly as they fused into one and experience omnipotence in the potential space of illusion in transitional phenomena, in which reality encounters phantasm. The interchange with the patient was greatly improved after such events. These pheno-

mena occur from the common unconscious between therapist and patient, i.e. therapeutic symbiosis described by Searles [11]. In the male patient, they appeared in the images of the therapist drawn by the patient.

Transitivism and appersonation, which promote the appearance of a transitional subject are not specific psychopathological phenomena. Benedetti [12] maintained that early infantile experiences, if they are described from the adult perspective, are all "transitivistic", and the mother fills the world of the infant with her own emotion and symbols, without which the world remains an enigma that is never cleared. Such a process of identification that occurs in patients with schizophrenia is a difficult but new version of early infancy. Here are the profound psychopathology of schizophrenia and clues to its treatment.

The girl with schizophrenia reported by Sechehaye [9] was given a doll and returned to the real world through confusion between the doll and herself. Sechehaye considered that this was a very primitive and magical mechanism of identification.

The transitional subject is a mechanism that works in the process of recovery of such enfeebled ego-conscious. The subject does not develop without approaches from outside as well as inside the person. At the same time, my own experience in treating schizophrenia allowed me to feel first-hand that the subject also has the aspect of a phantasmic subject.

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# Kasuistik

## Kognitiv-verhaltenstherapeutische Behandlung eines Patienten mit einer schweren posttraumatischen Belastungsstörung nach sexueller Gewalterfahrung[1]

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### Summary

Sexual assault of adult men up to anal penetration is one of the most unknown crimes even though their number comes to 10% of all rapes. This crime, aiming at humiliation and submission of the victim, also happens outside of closed male communities like prisons and military facilities and does not interfere with the sexual orientation of the victim. Only few men find their way to an adequate therapy.

Treatment of posttraumatic stress disorder (PTSD) is successfully possible with a cognitive-behavioural treatment based on the principles of confrontation and habituation and can enable the patient to again lead a normal life without PTSD-symptoms. Pharmacological cotreatment may be helpful during the entire therapeutic process. The social securing of the patient and a substantial therapeutic relation are the basis of this therapy. The setting has to pay attention to the therapeutic burden of the patient as well as of the therapist.

*Keywords: male rape; PTSD; in-sensu confrontation; imagery rescripting*

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### Einleitung

«male rape»: Vergewaltigungen von Männern durch Männer

Sexuell ausgestaltete Gewalt unter heterosexuellen Männern bis hin zur analen Penetration scheint selbst unter medizinischen und juristischen Fachleuten weitgehend unbekannt zu sein oder ausgeblendet zu werden. Die über sexuelle Gewalt von Männern an Männern vorliegende medizinische Literatur ist übersichtlich, da spärlich. Das Schweizerische Strafrecht kennt den Begriff der Vergewaltigung für männliche Opfer nicht; Art. 190 (Vergewaltigung) spricht explizit von der «Nötigung einer Person weiblichen Geschlechts zur Duldung des Beischlafes». Sexuelle Gewalt gegen Männer, selbst beim Tatbestand analer Penetration fällt unter die Bestimmungen des Art. 189 (sexuelle Nötigung) des Schweizerischen Strafgesetzbuches. Art 190 erzwingt eine Zuchthausstrafe; bei einer Verurteilung nach Art. 189 kann auch eine Gefängnisstrafe ausgesprochen werden.

Der Anteil von vergewaltigten Männern wird in den USA auf etwa 10% aller Vergewaltigungen geschätzt [1]. Die Vergewaltigung männlicher Opfer ist zumeist, ebenso wie bei weiblichen Opfern, nicht primär durch die Suche nach sexueller Entspannung motiviert, sondern ist eine Möglichkeit zum Ausleben von Macht, Kontrolle, Erniedrigung und Verletzung sowie der Erotisierung von Aggressivität [2].

1 Die redaktionelle Verantwortung für die Auswahl der publizierten Prüfungsarbeiten liegt bei der Prüfungskommission der SGPP.