modern
psychoanalysis

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A special volume of *Modern Psychoanalysis*

For the two issues of Volume 44 (2020) we present articles previously published in *Modern Psychoanalysis*. Each was selected by a contemporary modern analyst, a faculty member of a modern psychoanalytic institute and therefore both a practitioner and a teacher of modern psychoanalysis. We invited all members of our faculties to consider one article that has had an effect on them, that reverberates with them as they teach and as they practice. We asked also for some comments containing neither an argument for a particular point of view, nor a claim about the overriding importance of a particular concept of modern psychoanalysis; we were interested, rather, in an article that would come spontaneously to mind and would therefore have continued "speaking" to these analysts as they reflected on their lives as teachers and practitioners.

We wondered how their own practices, teaching, and personal lives had been affected, not only or necessarily at all by theory or technique but perhaps by some small, perhaps previously unnoticed thoughts that had served to tie some things together, making psychoanalysis a practice in which they could continue to grow. And so each selected article is introduced by an analyst/teacher. Since these articles have stirred the interest of these analysts and in some cases have done so over many years, we hope they might afford us a way to open up some of the per-

haps overlooked treasures contained in the history of modern psychoanalytic clinical thinking.

We view this project as an experiment aimed at retrieving what might already be known but not yet "spoken," about how modern psychoanalysis has remained a living force in the lives and work of its practitioners and transmitters. We hope to discover whether and how we have evolved as psychoanalysts over the forty-four years of the existence of *Modern Psychoanalysis*. We hope also that our "discoveries" of the past will open us to a future that we are always in the process of beginning to think about.

We wonder if there are features of our approach that have been confirmed so frequently that we no longer raise any questions about them. Might some of the prevailing assumptions about our work and teaching be ready for a new examination? Might there be features of modern psychoanalysis that we have given up, or that we don't pay much attention to anymore, without having given that process much notice? Have we perhaps also adopted some new strategies or ways of working that we have not reflected on, but which have become "standard?"

Even if no such modifications have taken place over these years, and we are practicing and teaching modern psychoanalysis at its most pristine, it is evident that the discourse that has been unfolding within the field of psychoanalysis writ large has brought us, as modern psychoanalysts, into dialogue with diverse groups of researchers and practitioners. We have also, through many years, been experiencing all along the social upheavals occurring in the "space" beyond the consulting room. As we think about the future and wonder about the role modern psychoanalysts will play in the social world that is always emerging, we might reflect more deeply on the place of modern psychoanalytic practice, teaching, and research within the various contexts of the larger society—political, economic and academic. The analyst's work in the consulting room has most often been regarded as entailing a kind of "bracketing," isolation from the external world, so that we might keep our focus on psychic reality. Yet we know at the same time that the individual psyche cannot be so readily divorced from the social milieu, in which it inheres in a way at least analogous to how it inheres

in the individual human being. As with trauma in our own lives, which we can know about without the knowledge itself affecting us, so might the dislocations and traumata being played out in the larger society, and within its institutions, leave us sometimes similarly unaffected.

In fact, if the dyad is the elemental social group, then we have always been concerned with the social dimension of the psyche and of the suffering that is so much a part of psychic life. Might we discover some new paths of access to exploring and perhaps also to addressing these "external," "social" realities, through an extension or modification of our own work as psychoanalysts, that is, as modern psychoanalysts? Perhaps we might begin to look at the psyche not as an individual, isolated self, but as a social form of relatedness.

Even such an idea as this is hardly a new one, but it has sometimes stood outside the central Freudian conception: an isolated psychic apparatus, attempting to regulate through its internal mechanisms its relations with the world around it, conceived of as fundamentally external to it, and as a threat to it. We might wonder, in short, about the aims of psychoanalysis in the world that is always emerging around and within us. Of course we have always known, or known of, that otherness within us, the unconscious, and we have also always "known" that the self-definitions we have been able to become comfortable with are the sublimations we have been able to create that have enabled us to achieve a kind of common unhappiness, as opposed to the constricted and rigid misery of neurotic unhappiness. The French psychiatrist/psychoanalyst/writer, Michel de M'Uzan, has characterized this common unhappiness as "permanent disquiet," and has claimed that it is the aim, in the sense of "result," of a psychoanalysis that has been carried through to its logical conclusion. It is the place in which analysands can be free enough to create their own best solutions to living with otherness, experienced both within the movement of their own subjectivity, as well as within their engagement with others in the social world.

We hope you will read these articles and their introductions with such questions, thoughts and shifts of perspective in

mind. We hope that we might, together, discover ways in which modern psychoanalysis might occupy more fully a "place" of "permanent disquiet" within the larger psychoanalytic discourse of today. Such a place would be one in which we come to ourselves in a process of continuous re-invention, understood in the sense of a continuously renewed self-discovery. Such a place is also the source of our capacity for creative thought and work. From this vantage point we will be in a very good place to renew our theory, refine our thinking, and improve our practice.

We hope, too, that you will send us your responses as letters, suggestions, or papers. We would like this journal to be not simply a vehicle for the exploration of ideas and for the examination of clinical material, but also a means for enhancing and enriching a discourse in which authors and readers participate. We hope to provide a framework for such dialogue. Response is integral to what is said or written, and we welcome yours.

William J. Hurst, PhD, LP

Drive theory in diagnosis and treatment

Phyllis W. Meadow

Introduction by Jane Snyder

A number of writings have been instrumental in providing me with some orientation when working with patients. The article, "Drive Theory in Diagnosis and Treatment" by Dr. Meadow is one of them. It is so much a part of my thinking that I seldom reread it, except when I'm using it in teaching, but rereading it again for this project was a particular pleasure. The paper offers a framework for thinking about patients diagnostically according to very early patterns of handling stimulation and tension states. As she does in many of her writings, Meadow attempts to describe the earliest levels of infantile experience, pre-object and pre-self object, when there is no differentiation between inner and outer, but the infant is beginning to organize representations of sensations as positive or negative, arousing or calming, and the impressions of the other as benign or dangerous, gratifying or frustrating. The balance between positive and negative, arousal of rage versus gratification of need, feelings of fusion versus aloneness with one's arousal states, and managing intrusions, even violence, through discharge or withdrawal—this is what we mean by a focus on drive states, discharge patterns and management of tension.

How can we think about this early time in a way that is useful to us as analysts? How does the infant begin to perceive and filter

sensations in creating a mind with an evolving ego and object field, inner and outer, self and other, arising out of these early experiences? What does this understanding have to do with being in the room with a patient?

In the first part of the paper, Meadow describes three early patterns of experience: alone in the world (no other presence), together with a dangerous sensation (terror of annihilation), together with a comforting presence (symbiosis, grandiosity, negative impressions suppressed). As self–other differentiation develops, longings emerge and frustration and aggressive impulses are handled in a variety of ways. Early fantasies and patterns of handling tension states develop. These patterns underlie diagnostic categories. If there is too much frustration, aggression may be turned against the developing mind in order to protect positive object impressions (leading to schizophrenia). Or aggression may be handled in feelings of worthlessness and rage against the self, in self attack and self–object criticism (as in depression). Negative impressions may be extrojected into the object field of the mind, leading to attacks on the other (as in paranoia). In borderline conditions, object impressions are split into bad and good part-object impressions and projected, leading to alternating sadistic attacks versus idealizing but devouring interactions. Incomplete self-object differentiation may require the continuing presence of the early object and suppression of negative feelings, leading to melancholia with the loss of the object.

Meadow describes different stages of libidinal object relations as well, distinguishing identification, imitation, love. She notes that love requires a separation between self and object, a recognition of the other as a separate person. While patients may come to us for help with relationships and finding love, pursuing mature developmental needs, early fundamental patterns of experience and ways of handling tension will come up and color any intimate relationship, including the analytic relationship. She makes the case for addressing in analysis all levels of experience, including the pre-object level, to free the patient to lead an emotionally satisfying life.

How is the analyst to proceed? The second part of this paper describes how understanding the basic diagnosis in terms of the balance of libidinal and destructive impulses, and the handling of aggression, helps guide treatment. While all modern psychoanalysts understand the importance of the contact function and its usefulness in treating withdrawn and schizophrenic patients, Meadow goes on to describe the analytic approach with other "types" of patients. She describes the importance of accepting

the critical patient's attacks—the projections of the paranoid patient, the self attacks of the depressive patient. Reassurance is not helpful. Countering the projections is not helpful. In the body of the paper itself and in the report of the discussion that followed its original presentation, Dr. Meadow gives useful guidelines and a rationale for how to work with patients in each diagnostic category, including, but also moving beyond, joining and reflecting techniques. She also offers her thoughts on interventions with common resistances.

As is true in much of her writing, Dr. Meadow, through her sometimes meandering way of making a point, leaves many nuggets of wisdom gained from clinical experience strewn among discussions of cases and recaps of modern psychoanalytic theory. It is well worth the meandering along with her—her points are valuable and useful to all analysts grappling with difficult cases. Among other nuggets are her thoughts on frequency of sessions, including a rationale for greater than once a week frequency, depending on the needs of the patient and tolerance of both patient and analyst.

The paper ends with discussion of a case in which the patient requested some action in the session. Meadow cautions that until action is understood it should not be indulged, and cites Freud's idea that analysis is a playpen. She concludes, "Analysis is the art of reading symbolic messages." The framework she offers in this paper can be of great assistance in making sense of the messages we receive and guiding our responses.

Drive theory in diagnosis and treatment*

In thinking about severe emotional illness, modern analysts have come to view the solutions patients use to deal with their emotional conflicts as variations on patterns of turning destructive impulses inward. It helps if we view these solutions as organized mental activity in which the flow of energy can

* A revised version of an address given to the Nassau County Chapter of the Society of Clinical Social Work Psychotherapists at the North Shore University Hospital, Manhasset, New York, on March 29, 1981. Originally published in volume 6(2) of *Modern Psychoanalysis*.

be understood as a method for mastering tension. Using object language to think about the regressed patient is usually an error. Pleasure-pain, tension reduction, overstimulation are terms which better fit the longings and rage with which the narcissistic patient is struggling. Drive theory provides us with the picture of conflict as an insufficient quantity of libido in the system to cope with the amount of tension.

It is clear in a reading of the psychoanalytic literature that despite our experience of treatment with the regressed aspects of a patient, thinking in drive theory terms is difficult for the analyst. When writing, we tend to convert phenomenological experience into self-object representations. When the feeling in the room with a patient is of vast spaces, we describe it as aloneness or emptiness. This is understandable since no psyche stood still at the periods we are recapturing. Layers of pre-object and object experience are added to the surviving psyche. But, the period of life experienced in psychosis returns to a pre-object state, and for the most part, a pre self-object merged state. Much of the experience recaptured in sessions dates to a dawning awareness of being and a responsiveness to that awareness of existence. The locus in which the patient experiences his existence may be a comfortable level of tension, which in object language is frequently described as symbiosis with a benevolent omnipotence. This is a state in which internal tension systems are in balance with stimulation. On the other hand, the patient may experience turmoil, a flooding with unpleasant stimulation. The patient's experience in the analytic office may regress to a vast and lonely emptiness described in object terms as a loss of a separate object field of the mind. Some patients experience emotional awareness in a state of terror or dread, described in object terms as fear of the witch in the nursery.

Although this paper will attempt to describe the treatment interaction in drive language, it is a preliminary attempt in which the author expects to fall far short of an accurate description of the real emotional experience with patients. The reader is cautioned to view all descriptions using object relations language as only partially successful attempts to recapture the experience, the failure being in the author's inability to create a relevant language for the phenomena of early interaction.

Working with oral regression

In a successful analysis, a patient tells us his preverbal history by regressing *in the office* to the first two years of life, to interuterine experiences and even to specific genetic memories. By reliving early drive states and the inhibitions developed to cope with them, each patient demonstrates how tension and discharge are organized in different personality types. Patients entering treatment with borderline conditions, severe character disturbances, or impulse disorders frequently attempt flight from the arousal of any object longing in the relationship with the psychoanalyst. Some examples follow.

Alone in the world

One category of patient conveys the feeling that he is alone in the world. He is cut off from all experience. Energy is used to reduce stimulation and control tension. He may speak in a monotone, make no contact with the analyst, and, although he reports thoughts freely, his experience does not allow for the presence of the analyst in the room. Early longings for physical contact had been denied to one patient by a physically and emotionally distant mother. When this patient, a European, entered treatment she was withdrawn but pleasant. She expressed no longings for emotional contact with the analyst. The only sign was a conventional handshake at the end of each session. When this action was explored, the positive attitude to the therapist changed to a hostile explosive one, but any meaning was dismissed except, "That's how we do things." When her analyst suggested they give up the handshake, she reverted from rage to despair and as the weeks went by without physical contact, to apathy. The absence of physical contact recreated the original situation with such force that understanding was useless.

One of my patients began analysis in that state and, in the analysis relived the intensity of preverbal experiences. Now he can verbalize the emotions of that period. Describing the change, he says, "It's not a place of darkness. I feel larger. I have wishes." (When remembering he speaks of despair of the real world and profound emptiness.) Inner and outer is equally bizarre. "I'm riding in my own death landscape."

In a recent session, he reported a dream fragment. (A dream fragment indicates that the patient has a problem, but not a solution. This is particularly true when the fragment is dreamed repetitively.) This man's wife is pressuring him to have a baby. This pressure from outside reminds him of his first awareness of another presence. When his wife wants something he feels it as a demand that enters his body, then requires action of him. Regression to a pre-object isolation is a defense against tension-producing invasion.

> My wife and I are alone. Suddenly, my parents are sitting behind me (also in the analysis the presence of the analyst behind him produces tension in the patient). My father is holding his jaw … a toothache. I ask him how he is. He says, "Not too good. The doctor says it's probably cancer." I stand up and say, "Oh, No." With a sense of pain, I embrace him.

This patient's father and his wife have needs to which he is required to attend. He entered analysis an isolate. His first positive transference feelings were of "a tentative entry into the world—being born." When I speak and say what he wants to hear he feels he has magically created the proper environment. If I sit behind him quietly, he feels swallowed. As he says, "I can feel safe only if I get you to talk, then I know that you are here (and not separate or demanding). I'm located back there most of the time and cannot seem to move forward into fatherhood."

His reaction to the pressure for a baby led to problems in maintaining an erection and failure to ejaculate. He explained that he spent all his life trying to get out of the uterus and now he feels pushed back in. He sees a baby as a lock and key. It arouses his desire to be free. Now he feels isolated again.

Together with dangerous sensations

A second category of patient conveys that he is terrified of the analyst. "Stay away," his behavior says. "You are dangerous." The experience of danger is the first impression to create consciousness. Until discomfort reaches a certain intensity, the infant is merely a recorder of sensory impressions. When those sensations are negative an infant is aroused to awareness of the other not as a person, at first, but only as a locus.

Such a patient describes to her analyst her fear of her supervisor. She expresses only positive feelings for the analyst, typically splitting good and bad feelings as the infant does before developing the ability to integrate negative with loving feelings. In the following session, she describes the bad space:

> I am terrified with her. I feel rage, anger, frustration. She takes me to another room to fight, and I've never been in that room before. It's a different room of emotion, not something I'm familiar with. The feeling is total inability . . . terror. She may throw me out and I may go. I may commit suicide. I never get a sense of equality with her. Always get the feeling I'm one down and I fear for myself. It's an old fear, peculiar, and something I want to avoid. It's not something I have experienced as an adult. Helplessness . . . needing her badly . . . not being able to tell her I need her emotionally. When we get into that place together I feel helpless. I don't stick with anger. I don't feel I have control over my density as I do when I'm with you and my husband and other people. It's primitive, terrifying. She gets angry; I want to withdraw. It may be the enraging way I present to her that makes to want to withdraw. I can't explain it except to say, I never get the response I need from her. I can tell you about the things that frighten me in my relationship to you. I only feel annihilated with her. You never annihilate.
>
> (She describes her good object.) That's the most wonderful thing about you. If I were to describe the most beautiful thing about you, it's that you at your core never annihilate anyone. It's the most extraordinary thing. Why do I experience most people as capable of annihilating me. In fact, you're one of the rare people who doesn't. As lunatic as my husband can be he doesn't either. I'm able to talk to you and have you talk to me without driving you crazy, but with her I get into this situation where I can't wait to get out.

Unlike the withdrawn patient who lives in the shadows, alone in a room filled with vast spaces, this patient experiences a negative presence, not a person but a presence with only one dimension, terrifying or benevolent.

Together with a comforting presence

A third category of patient conveys the bliss of symbiosis. "I feel wonderful. I can do anything." And the unspoken message: "You are a part of me. Don't say anything to interfere with our

oneness." The negative state out of which consciousness is born is temporarily eliminated when the infant creates the image in his mind of a friendly force. Grandiosity accompanies feelings of well being as the mind creates the visual image of the good object that does its bidding, much as an arm moves on an order from the brain. In this stage of development, a patient gains security through the creation of a benevolent analyst. The fantasy creation is maintained, however, at great expense to the ego. The suppression of negative impressions, continuing to press for discharge, requires an investment of available libido.

Coping with a tension-producing presence

A fourth category of patient engages in object protection by redirecting rage against the self. "I hate myself when I hate you." Because of intense tension, hallucinations of gratification cannot be reproduced. Fantasies of revenge create terror and a self-object hatred emerges. Patients attack themselves rather than activate vindictive fantasies because, like an arm, the positive object impressions are a valued part of the self. This category of patient has been described by Spotnitz (1969) and Clevans (1976).

Tension produced by intimacy

A different form of self-attack was manifested by a homosexual man with a history of tumultuous relationships and painful interactions with sexual partners. Having established a predominantly satisfying relationship with a male, he expressed a fear of giving up promiscuous sex. He could not explain his restlessness. Looking at his arousal patterns provided a clue. Both longings for gratification and for sadistic sexual experience were repeatedly aroused. His search for a male companion would bring him into contact with a new person. In the interaction, he would identify his new companion as a decent fellow or a sadistic bastard. Having established one or the other perception, he would proceed with the sexual encounter. With the decent fellow, he longed for oral sex. With the partner who aroused negative feelings, he craved penetration and anal sex.

Monogamy and satisfaction with a mate did not prove to be enough. No outlet for vindictiveness or conflict was provided.

The thought that the relationship was deep, satisfying and good left him feeling restless. A craving for food emerged. The patient continued to perceive his intimate relationship as wholly satisfying, had not moved to an integration of love and hate, but instead to compulsive eating.

Diagnoses re-evaluated

As analysts we use object language because of our own development and method of perceiving. The phase of life we observe when the patient is orally regressed is one of tension discharge. And it is important to remember that during this period there are no clearly perceived objects. It is a phase when thinking is done through a reprocessing of internalized visual and auditory impressions and bodily sensations. The patient in the preverbal period is engaged in methods of tension reduction.

These patients solve their emotional conflicts by returning to patterns of feeling and behavior which in infancy, in the absence of object constancy, were their best ways of coping with tension. Each of our patients, when confronted with destructive urges, returns to his own early adaptive modes, whether isolation, terror of connectedness, omnipotence or self-attack.

To understand the way orally regressed patients relate to the analyst requires a shift in our thinking about the transference relationship. We see the development of a narcissistic attachment in patients when patterns of self expression emanate from pre-ego tension states. The transference manifestations are different from those of patients whose emotional growth continued successfully through the use of speech and who can use language to elaborate more complex defense measures to control impulse discharge.

A good example of the analytic experience is offered in the story of Orpheus and the compelling power he exerted over all of nature, animate and inanimate. The experience of Orpheus offers a metaphor for our early omnipotence, one method of tension reduction available to the regressed patient. It was believed that Orpheus' music summoned the sun up into the sky

each morning much as an infant's cry wakes a mother, and in waking her, creates her.

When an adult regresses, he returns to the impulse control mechanisms of primary process thinking and in the extreme, to hallucination. The early infantile period relies on visual and auditory impressions, not thought, to sort out experience. An infant, and a regressed patient, will, like Orpheus, seek a reassuring interpretation of frightening events. When no higher order of functioning is available, it is an adaptive feat to recollect gratifying experiences. When a memory of gratification is aroused with such intensity that it cannot be distinguished from reality, it is called a hallucination. Hallucinatory wish fulfillment is the first form of mental activity to interpose some delay between tension and discharge. The ability to summon up a gratifying hallucination is one of the earliest accomplishments of the emerging ego.

If we imagine a hungry infant coping with physical and emotional distress by conjuring up the image of a flowing breast, we must admit that he is demonstrating a high level of maturity in his method of coping with frustration. To create a hallucination the infant must recall a trace of pleasant sensations and images. A visual or auditory image connected to a memory trace is reproduced to comfort the infant, he is reassured and tension is temporarily reduced. However, an infant soon learns that satisfaction does not flow from the fantasy of nourishment. Freud compared the infantile attempt at fantasy fulfillment to the reading of a menu card in a time of famine.

Hallucination, then, is the beginning of ego. The ability to call up a reassuring image in the face of deprivation is an act of ego. When the infant continues to experience tension, the mind is called upon to take a further step—it must begin to differentiate fantasy from reality. An intermediate state is the use of motility with fantasy, a motor hallucination, as seen in the imitative play of children who alter the world to create the wished-for event. When the analyst works with oral regression he helps the patient to convert hallucination and other forms of discharge into words, thereby integrating preverbal visual

memories with later perceptions. Magical thoughts are tested against reality as the ego grows and, with that testing, the patient, like Orpheus, learns the limited place he occupies in the whole. Disappointment and relief often accompany the realization that without him, the sun rises anyhow.

When thought replaces hallucination, thought can be used to direct action to cope more realistically with frustration.

In the infantile psyche, severe frustration mobilizes aggression. If aggressive energy is not directed to motor discharge it backs up and becomes self directed, thus establishing discharge pathways which have the capacity to overwhelm the psychic structure. The result may be symptoms such as mental confusion or stereotyped and concrete thinking. If the early nourishing image has been contaminated by a depriving image, aggressive energy may be channeled into fantasies of annihilating the hated object. Libidinal energy may then be deployed to protect the positive image. This intrapsychic picture, from the psychoanalytic point of view, is of libidinal or positively charged energy used for defensive purposes against negatively charged energy which creates the wish to annihilate memory images and the fear of retaliation (Spotnitz and Meadow, 1976).

We find, then, that an individual who has not progressed beyond the fantasy level of gratification may respond to the longing and frustration aroused by the analytic situation with fantasies of destruction. Narcissistic personalities are given to retaliatory hallucinations as well as gratifying ones. In psychoses the individual attempts to inhibit the life-threatening fantasies of destruction by defenses designed to protect the object image, but, at the cost of the personality, e.g., fragmenting the mind, blotting out stimuli, concentrating on body symptoms, or engaging in merciless self-attack.

In regression to this early state, images in the mind are the real world, actual people are shadows of these images. A patient who experiences intense object longing, rage and the wish to annihilate says, “I want to kill you to get you out of my head.” In order to avoid these feelings, the psyche devotes itself to the

task of denying feelings of object hunger and feelings of deprivation. Remaining energy is utilized to ward off anxiety, rage, hopelessness and helplessness.

In the following emotional states positive fantasy has been overthrown. Fears of vindictiveness must be warded off.

Schizophrenia

When in a conflict between the desire to destroy and the desire to preserve gratifying visual impressions in the object field of the mind the cost is the destruction of cognitive functioning, we speak of schizophrenia. The patient prefers confusion to feeling. His actions tell us it is better to have a blank mind than to think disturbing thoughts. The patient may be said to be immobilized by destructive wishes. Bottled up destructiveness interferes with thought and perception. Schizophrenia is a diagnostic picture in which libidinal energy is used to blot out thoughts and feelings, but in which inhibition of hostile imagery occurs at the expense of a mental organization. When the destructive impulsiveness presses for expression and the schizophrenic defenses fail, we see further attempts to contain the impulsiveness in somatization, self-mutilation, suicide and displaced homicide.

The most severe regression is seen in the catatonic schizophrenic. Like the others, he is unable to love or to identify. Destructive impulses have overwhelmed most of the available energy. The remaining libidinal energy is utilized in denying negative wishes. To prevent destructive action the patient has immobilized himself. With energy thus tied up, he has only enough left for the most rudimentary form of identification—aping gestures. These gestures are the catatonic's way of remembering early perceived object attitudes toward himself. At this minimal level of functioning visual images integrated with negative feeling states produce the gestures to which no comprehensible meaning can be attached, until we examine them in terms of longings experienced when sensory stimulation first roused the infant from satisfaction with the vegetative state into pleasure and rage in interaction with the early environment.

Depression

Severe depression presents a different picture from schizophrenia. Negative tension states are connected in memory with the first awareness of the environment. Negative impressions cannot be shaken off. The result is that the patient feels worthless and hopeless. If the longing for fulfillment is insufficient to bind the quantity of rage, the path is open to motor discharge in the form of physical destructiveness, including suicide. To escape from the pain of self attack, aggression may be turned outward in an attempt to annihilate the early memory image, now externalized or displaced onto a current object. Again, the patient says, “If I obliterate the image of you, I will no longer be troubled.” Unfortunately for the depressive he has difficulty shaking off internalized object-self impressions. Unlike the schizophrenic who attempts to obliterate all feelings and perceptions the depressive preserves resentment and is intolerant of the hateful feelings he cannot escape.

Melancholia

Another patient, a melancholic, develops stable relationships enabling the positive fantasies to be maintained. In such cases the mate, child, or parent is experienced as a part of the person and the patient feels completed by the constant presence of this extension.

An elderly woman came to my attention after the death of her mother. During her childhood her youngest brother was adored by both parents. An older brother was more moody and depressed; he seemed to be a loner. Their home was a center for young people attracted by the younger brother. Gathering around the piano, the young people sang while her brother played. She was included in the crowd and frequently paired with one of the young men. She accepted invitations to skate and dance, but when a young man seemed too attentive or serious, she would abruptly stop seeing him. She complained to her mother that one had put his arms around her or tried to kiss her. She and her mother then agreed that this was truly a disgusting person. She reassured her friends that someday the right man would come along.

After her graduation from high school she developed a variation on this theme. When the right man comes along he'll realize I have to help my mother and he will be good to her. She never married. Her brothers went to college and later established families of their own. She suffered from the depressive's low self-regard, but she was able to allay these feelings by remaining with her mother whom she described as a wonderful woman who needed her very much. After the death of her father, the relationship was even more rewarding. She and her mother joined clubs, took their meals together and she assumed the role of family head. The annuity on which her mother might have lived comfortably was put in a bank so they lived on a salary she earned by copy editing.

During these years her life was stable. Her mother was irritable and critical of her. As the time of her mother's death approached, she indulged in repetitive self-attack and cried easily. In the last months of her mother's life she came to the attention of social agencies to whom she reported her incompetence in caring for her mother. She would forget to go to her mother's room and to feed her. When she realized this she beat her chest and called herself names. She could not arrange nursing care or call the doctor in emergencies. She became a "lump" dependent on relatives and neighbors to see her through each day. Shortly after her mother's death, she found herself worrying about her brother's daughter who was so burdened by the young children she had. She spent much of her time worrying that she was not helping her niece enough. Eventually she was invited to spend weekends with the family, and she took it as her responsibility to spend all her time with the youngest child, a little girl. In this new situation she was able to restore the emotional stability she had had for most of her life.

Paranoia

Unlike the depressive who through self-attack attacks the early image, the paranoid patient locates a hostile presence or a bad self feeling in the external environment. Libidinal energy is not available for wish fulfilling object impressions; it is invested in the defensive function of denying painful negative percepts—a struggle against re-experiencing helpless rage, inadequacy, and

a feeling that matters are out of his control. Through the externalization of frustrating and critical portions of his psyche he is able to maintain some internal equilibrium. (See *Treating the critical patient* below.)

A modern theory of treatment

The regressions described above are not seen frequently in pure form in outpatient practice, but an understanding of early defenses enables us to recognize the vestiges of these patterns in the patients we treat. At various times in a patient's treatment we do see conflicts centered on love, identification or hate. To love, a high level of psychic integration, requires seeing the object as separate. Patients conflicted about love may be struggling with fears of intimacy based on unresolved conflicts around separation. Hate, like love, requires a separation between self and object impressions in the object field of the mind. At the narcissistic level, when the patient hates, he hates himself.

To identify requires the availability of less libidinal energy than loving. It requires only an image in the object field of the mind that can be experienced as a part of the self. In the omnipotent phase, we observe the patient creating good feelings about the self by becoming an extension of an idealized narcissistic transference object. In these cases we find libidinal energy vested in extrojecting satisfying self-object impressions while denying negative impressions.

Even less libidinal energy is available for imitation. In the stereotyped gestures of the catatonic patient we observe that longings are present as is rage frozen into a re-creation of the hallucinated early impressions. In catatonic regression, a patient simultaneously attempts to eliminate longing and demonstrate the conflict between longing and vindictive fantasies. Since the psychic system has lost its ability to retain object images, a swallowing-whole expresses, simultaneously, longing for the visual impressions and a warding off of longings to prevent the arousal of vindictive fantasies. The barrier the patient creates by freezing his body in stereotyped gestures reminds us of the babe at the breast who goes rigid as he struggles with a nipple he cannot retain in his mouth.

The tendency to visual and auditory hallucination is a form of regression which hospitalized psychotics may display during waking hours, but which our more mature patients tend to restrict to dream sleep and fantasy life, maintaining the ability to separate these experiences from the real world of events. The more mature patient in private treatment can usually produce a fantasy or a dream when he wishes to bring to the analyst's attention an early conflict that cannot be put into language. One of my patients produced a dream in which he experienced what the psychotic experiences when awake. The patient's father had died the previous week. The dream:

> I saw my father running. I knew he had heart trouble. I knew it was dangerous. I called to him as he ran around a corner. I ran after him and ran into an apartment he used to have. He had disappeared off the face of the earth. The police were there and couldn't explain it. (The patient experiences the feeling that death is incomprehensible; so is separation.) Then I had a revelation; he had disappeared into me. I had his clothes on and I smelled like him.

Through this dream the patient dealt with a traumatic loss and offered himself a solution through incorporation.

The treatment of withdrawal

If a patient takes emotional flight to avoid tension in the analytic relationship, the analyst respects the defense of withdrawal. Its use to block out excessive stimulation, serves a necessary defensive function. A modern analyst is trained to observe the contact function of the severely regressed patient and give him minimal, but sufficient, stimulation. (Contact function is the patient's manner and timing of reaching out to the analyst.) By observing the contact function we mean responding to the patient's requests for contact. No new topic is introduced by the analyst and, where feasible, the analyst speaks only in response to a verbal request. Patients usually contact an analyst by asking questions. A withdrawn patient who has not been contacting his analyst may begin by asking, "Are you there?" This means a swing has occurred from the expectation of a negative outcome from contact to hope of a pleasurable outcome. If a patient is incapable of any contact

with the analyst, it is desirable to reflect two to five of the patient's statements (Spotnitz, 1969).

Treating self-attack

With the depressed patient who maintains negative impressions from his infantile experience through expressions of self-hatred, the patient may leave treatment prematurely if the analyst insists that he is all right or makes other positive communications that threaten his defense of self-attack. This works with the depressive patient in much the same way as making too much contact does with the withdrawn patient—it leads to further regression. Bearing this in mind the analyst does not deny the reality of the depressed patient's negative views of himself. I treated a patient who suffered extremes of inner turmoil. Traumatic digestive difficulties had plagued her infancy. The repetition of this inner tension was expressed in object language: critical object, bad self. She read in the news that schizophrenia was being treated by dialysis. She was taken by the idea that schizophrenics simply need "new blood." I asked her if she should try it and she replied, "In my case they'd have to replace some other parts too." Behind this statement lies a repetitive but disguised complaint that I have not given her a new life by getting rid of the worthless part of her. All the self-attacks of the depressive contain a criticism of the object. Frequently the analyst experiences the feeling that she should be doing a better job (a narcissistic countertransference). At these times the temptation is to reassure the patient in order to get rid of the feeling the analyst is experiencing that it is a hopeless situation and, in fact, maybe the analyst is not all right. The earlier conflict, predating established object relations, is an important part of the sessions. On one level, it resembles the colicky state with both patient and analyst experiencing distemper.

Treating the critical patient

In paranoid states the analyst is confronted with a different treatment issue. Since the patient tends to externalize feelings of inadequacy, discovering example after example of the analyst's failures, he is unable to integrate interpretations offered or to engage in self-examination. He experiences any direction

from the analyst toward introspection as a sign of the analyst's malevolent feeling for him. This is related to early object relations in that the patient's inability to cope with the tension in his systems was first experienced in the maternal interaction as a flooding of self-destructive impulsivity. Later he was able to separate out the critical portion of the self-other merger and extroject it, seeing malevolence and inadequacy emanating from the environment-mother-analyst.

When, in the treatment, the patient complains that the analyst is jailing him, controlling him, ruining him or his reputation, invading him, pressuring him, violating him, the student analyst is not encouraged to acquaint the patient with her own perceptions of reality, but, instead, to begin by accepting the patient's perceptions and projections as if they had an external reality, remembering that the patient functions as a closed system protecting his ego from new perceptions and feelings.

One of the most difficult states to resolve is that in which the patient feels right. He knows he is right and defends his views. The analyst may spend many months exploring but not challenging the patient's perceptions. The analyst does not deny when the patient says, "You think, you feel, you said, you did." The manner in which these communications are explored is important. A negative response based on induced feelings will arouse more defensiveness, feelings of being misunderstood, or flooding owing to a loss of omnipotence.

When a narcissistic transference is firmly entrenched, the patient is ready to weather a few storms. Then we may direct comments to the patient's defense, e.g., "You don't want to hear my opinions on that," "You know you don't want to hear anything that challenges your idea," "You know you want me to agree with you and tell you that you are right." The patient is confronted with the fact that he does not want to know anything he does not already know. The patient can tolerate this if the analyst is seen as a valued extension of the self. Eventually the analyst goes further stating, "You don't want to because. . . ."

The patient is introduced to the notion that his mind is a closed system. It is painful, and he fears the analyst will abandon him if he is inadequate so he struggles to maintain his position. On the

other hand, he cannot tolerate the image of the analyst as malevolent, inadequate or wrong. He cannot let anything in that will cause him to feel inadequate, responsible, inferior, or any other bad feelings about the self. He also needs a good and powerful object with whom to identify. This is the basic conflict in ego formation—early negative self-impressions and object impressions, neither acceptable. All available energy is used to throw off these negative impressions and to create unity and bliss.

In the following exchange a patient complains about my treatment of him in group analysis. It is a discussion during a private session in which he accuses me of ruining the group by favoring one patient to the exclusion of everyone else. He says:

"It's very destructive to me when you give so much time to John." In an angry tirade he describes the other patient as a defective and himself as superior. He says, "You give him all that attention because he's a basket case." He adds, "That's what you do but you'll never admit it. Just tell me, why do you do it?"

The analyst's response, "You don't know yet," joins the defense of knowing it all. Whether or not the patient is right is not challenged at this point.

> P. Yes, well, why don't you tell me?
>
> A. (Repeating something she has said frequently during the past year,) You don't want me to say anything that disagrees with what you say.
>
> P. That's ridiculous. You don't think I want to believe that you're doing it for no good reason, do you? (Here the patient demonstrates the conflict: he deals with bad feelings by externalizing, and, he wants also to believe in the competence and caring of the analyst.) I want to believe you have some plan. I'd like to think you do things for a reason.
>
> A. And you want me to agree with you that I am doing what you say I'm doing. (This is a new communication.)
>
> P. (Misunderstanding) No, I can't accept that that is what you are doing.
>
> A. You want me to admit I pay more attention to John and give you a good reason for it.
>
> P. Yes, I want to believe that there is a good reason for you to be doing what you are doing. Just tell me any reason that will be

> acceptable to me. (Here we can see that the patient is ignoring the possibility that his perception may differ from the analyst's perception.)

The patient wept when he asked me to admit he was right. (When a baby cries, he asks for reaffirmation from the environment that all will be well, and simultaneously he announces something is wrong.) For this patient, if I do not agree with his perception, he cannot be sure of it though he will cling to it tenaciously. The patient doubts his sanity when the analyst perceives differently.

This patient is only conflict free when he can believe in his perception and in the omnipotence of the analyst. Because of his need to repeat the past, he continues to turn up evidence that the analyst does not care for him, and moreover, is a bad person.

> P. (Revealing negative narcissistic transference.) You do what you do to be irritating and provocative, to see how much you can get away with. The group lets you get away with murder. (He demands that anyone who takes group time be quieted. He never reveals how unloved he feels. He is outraged when a dialogue continues too long, but does not say, "You don't care about me. You love him more. I feel devastated when I think that you may not love me.")

Our goal with patients is to help them to say everything and thus increase their contact with the unconscious. The problem with this goal is that patients don't want to know what lies in the unconscious. They don't like the vision of human nature that says we are all murderers and seducers. Rather than know, they act.

Summary

The treatment techniques described are used with patients who, although functional, are dominated in their daily life emotionally by one of the primitive pathological solutions to emotional conflict. We've found that any diagnosis that helps explain the patient's characteristic patterns and helps the analyst to predict future psychic events, will facilitate his work with that patient. In a successful analysis, the patient experiences every unresolved conflict within the transference, both pre- and post-verbal, which, when raised to the verbal level in the transference relationship, offers security against future illness.

Concepts

The concepts found most useful are:

1) Patients when regressed have preferred patterns of defense that originated in the prehistoric period, e.g., withdrawal, self-attack, externalization.

2) To understand, dynamically, the character of the patient, the analyst looks for bottled up destructive impulsiveness. The psychic balance between libidinal and aggressive energy determines the pattern.

3) The mature personality is one capable of experiencing frustration and object hatred without needing to destroy either the self or the other. In fixation or regression to preverbal levels of functioning, the available supply of libido is tied up in the defensive task of preserving gratifying impressions and denying negative images. When the patient is confused, when he distorts external reality to ward off internal impressions, and when he withdraws cathexis from positive impressions, we no longer doubt the meaning of the apparently garbled messages. Applying the concepts of tension regulation, we observe how each patient maintains psychic stability.

It is important to work with patients with the idea that no one theory is adequate to explain all our cases. Through an emotional experience shared with a particular person, the analyst arrives at an understanding of the factors which shaped that emotional life. The concepts discussed here deal with how our patients may have reacted to the aural and visual impressions of earliest infancy. Knowing how these impressions may linger in the adult personality can help us during those periods when preverbal conflicts are aroused in the transference and countertransference. If we remain open to learn from Adler, Freud, Jung, ego analysts, existentialists, object relations and drive theorists as well as our patients, we will not freeze into a single theoretical orientation, but will grow with what each patient has to teach us.

As our patients integrate early aural and visual impressions, sort non-ego from ego, external from internal impressions, their energy will be freed for further growth including the capacity for love.

When our patients present different patterns of relatedness in the transference relationship, patterns based on the existence of a separate self, they require different interventions. But, it has been my experience that a patient, if seen long enough, will need to be related to in ways appropriate to the conflicts of early infancy as well as to those of later periods.

Discussion

Question from Audience: You mentioned that when our patients talk about the past it is a resistance. Can you explain that?

Answer: Yes. If a patient were to enter my office and talk repetitively about his past, I would assume he is resisting living in the present. That probably doesn't sound strange to anyone except a psychoanalyst who has been trained to understand the present as a reflection of the past. If we think about it for a minute, the patient who is cooperating with the analyst brings into the present relationship with the therapist his conflicts and his repetitive ways of coping with these conflicts. It is by showing us his past that we learn about it. Later, as specific conflicts are resolved, the past can be verbalized and this verbalization serves to corroborate the roots of transference manifestations.

Q. What you said first to the paranoid patient . . . can you explain?

A. The problem with a patient in a paranoid state is that he is always right. After establishing a narcissistic transference we may begin to bring to the attention of the patient's ego the fact that he doesn't like to hear anything contradictory. The patient is more amenable to this confrontation when the analyst's tone does not convey annoyance with the patient. After the patient has indicated that he can hear that he does not like to hear anything he hasn't already said, clarification may be offered. He is asked to examine examples of his need to be right—times when he rejects any other possible interpretation. He is encouraged to entertain the possibility that everything he already believes is not necessarily the whole story. In this manner the patient's closed system begins to open up.

Q. If the emphasis is on the present, then is there no attempt to bring the past into relation to the present?

A. No. Reconstruction is an important part of an analysis. Usually connections are made to the past when the patient has an aha experience in the transference. When a patient has felt understood, experienced a new feeling or resolved a block to saying some-

thing new, he may produce a memory. It is in these emotional contexts that a memory serves to corroborate the experiences being relived. When the patient tells something of his past prior to a resolution of a resistance, he may be reporting his distortions of the past to please or distract the analyst.

Q. Will you repeat what you said about it not being a good idea to tell the depressive patient that he is all right?

A. Yes. The depressive patient is busy telling you that he is no good. When you contradict him, you are attacking his defense. He needs that defense. And frequently it is helpful not only not to contradict him but to use the feelings he induces in you to agree with him. In fact, sometimes I think they are worse than they think they are. They really enjoy hearing that sometimes. They laugh. That, by the way, is one of the clues we have that we are reaching the unconscious—the patient's laughter.

Q. You described aloneness, symbiosis and object protection. I'm not sure how you are suggesting aggression be dealt with in the first two categories?

A. Actually, object protection plays a role in all these conditions, but the important factor, when working with a withdrawn patient who denies the presence of the analyst in the room is to recognize that he needs to be alone in the room in order not to experience dangerous feelings. He has returned to a level where the world is a grey world of shadows. Object protection is far from his awareness. The analyst's task with the patient is to make the world safe enough so that the patient can tolerate being with the analyst in the room. Although we are used to thinking in object terms, it helps to forget them. The patient is dealing with images or plastic photographs in the mind. If the impressions are experienced as friendly, he approaches; they are experienced as friendly when the analyst is not overstimulating, not necessarily when the analyst acts friendly. Until the patient is ready to ask, "Are you there?" he has stopped feeling his feelings and he has stopped perceiving anything external that might arouse longings or rage.

I had an experience of that at a lecture where a patient's analyst and I were standing talking at the podium. The patient walked up and spoke to me at some length then walked away and sat down. Later she asked her analyst if he had attended the lecture. He reminded her that she had been standing with him at the podium, but she had totally dissociated him from this setting.

Q. How would you handle the patient who is both withdrawn and feels omnipotent?

A. Which pattern has surfaced? That is the one requiring our attention.

Q. continued—He addresses himself to the analyst. He wants nothing to do with the rest of the world. The analyst is the only person he does not feel is beneath him.

Audience. Is it possible to join a patient like that?

A. How would you join him?

Audience. Agree with him. Find out why you're excluded from the category of the others.

A. When you question this patient you may find he is tied to you by magic. Your power is his power. He may believe the analyst knows all he feels. The patient may just want to be with you, feel wonderful and complain about the rest of the world.

Q. What is behind the defense of isolation?

A. I think of the earliest preobject period when the patient cannot hold a constant object in the mind. He keeps an intact ego by blotting out. If overstimulated, he will report confused states of mind. Left alone, he will present a good appearance, even talk relevantly. When working with the emotionally withdrawn patient, all that we find missing is that the analyst does not feel connected to the patient. A little sorting out is needed to distinguish between subjective feeling states belonging to the history of the analyst and induced states resulting from the patient's isolation. It is common when with a withdrawn patient for the analyst to feel sleepy, preoccupied, in need of a medical checkup or even confused. Coming out of one of these states the analyst may wonder why she drifted off. There may be a feeling of surprise as attention is refocused on the patient: the analyst may be surprised to discover someone is there in the room.

Q. I have a patient like that. The only time she seems to be there is when she is talking of the death of her mother. It's as though it happened yesterday.

A. That was the day her annihilation fantasy was realized. For the analyst with her in the room, sleepy could be the right frame of mind. The analyst's detachment is preferable to ambition to help the patient. When the patient begins to make contact, then the analyst will wake up.

Q. Is there a correct way to interpret the narcissistic defense?

A. The analyst may interpret anything. Usually, if the tone of voice and the timing are right, it is like water off a duck's back.

The correct time is when the analyst believes the interpretation will resolve a resistance. A patient may say he wants the analyst to tell him something. If the analyst tells him something and he gets better then you have a patient who can profit from hearing your perceptions. Fairy tales are wonderful. They tell us all about the unconscious. And some patients profit by hearing one that is related to a message the analyst is receiving from the patient's unconscious.

Q. What about the patient who is able to attack the analyst and does not bottle up aggression?

A. If a patient is attacking me, I am interested in why the patient is attacking me. Does he have no defenses against repetitive suspicions? I remember a woman I treated, a singer, who was in group treatment with another analyst and had developed a block to singing. The group analyst suggested private sessions to her and told her she had to get out her rage. She boomed into my office announcing that she didn't like my waiting room. She also didn't like the way I dressed nor my voice. This continued for five sessions and I was perplexed. In the meantime she was congratulating herself in her group sessions for her freedom to express herself. Finally, I asked her why she was lambasting me and she told me what her group analyst had told her. I told her it wasn't necessary and she became meek as a lamb. She was having a lot of fun for a while but then she got to her true character.

Q. I have a patient who wants to be in love with me but not feel humiliated by it. The patient believes he can only continue treatment if I can tell him a way to feel love for me.

A. Since loving will make him feel foolish (his perception) I might want to know what is to prevent him from staying without loving. We assume love is experienced by him as dangerous since he is not a separate person. Loving and merging are synonymous. In preverbal states, intimacy can be experienced as dangerous. This patient may need to come without loving for now. Can he tolerate that? We might ask the patient to help us understand it better—and to come for now without love.

Audience suggestion. Couldn't he come and feel foolish?

A. That's a good question for many patients. In this case I base my response on his repeated request to feel love without feeling foolish and I accept his perception that he cannot stand to feel foolish. Also, he is telling us it is foolish to love, so why not forget about love for now?

Audience. Is it possible he feels he won't be loved back?

A. Yes, and now we're talking on an object level. A patient may say, "You don't love me." and still not be talking on an object level. His concern may be with an intrapsychic state in which he loses his feeling of self.

Therapist. What if I feel I can never love him enough?

A. That is a feeling and one to be expected with a patient in this conflict. In assisting the patient to say everything and thereby acquire a tolerance for intimacy, the analyst first overcomes her own resistances to verbally entertaining any possibility—sex with the patient, shooting the patient, taking him home as an adopted child, or loving and marrying the patient. These are feelings that are put to the patient as questions and with feeling. In a group session last night, a woman reported that she could not leave her husband despite the terrible things he does. One of her children complained that she let him treat them that way. She said, "I can't leave him because then I would be alone." I asked her why she would be alone and she said, "No one else would marry me." I asked each of the men in the group if they would marry her. They all said, "No," and gave very valid reasons, e.g., "I'm already married." Not one offered to marry her. Why were they so unresponsive? Was their preoccupation with reality induced by her? But then we got to the really interesting part. One of the women asked why I had only asked the men. She was wise to this patient's need for mothering.

Q. A patient who describes herself as a piece of garbage was impressed that I would work with her despite that fact. It helped her to feel less depressed. Then she regressed again. She fears she can't talk in the sessions. She doesn't have anything to say. She doesn't like the way she looks. She never asks for any help. She just complains. I finally asked her how come she never asks for any help. The next session she expressed annoyance and said she thought she had been asking for help.

A. The patient thought that by telling you she was worthless you might understand the problem, figure out the solution and tell her what would solve her problem.

Therapist. You know, I really do feel hopeless with her. I want to get rid of her.

A. To berate the self interminably is a form of resistance in the analysis. With such a patient the analyst has all the right feelings when she feels she is doing a lousy job as an analyst, the patient and the situation is hopeless and neither one of them is any good. Joining the defense may be used when the patient repetitively attacks herself and the analyst gets the feeling it is hopeless. If a

patient is joined infrequently but with dramatic emphasis at a moment of heightened feeling it is possible to reverse the pattern of turning aggression inward.

Therapist. When she and I were agreed that she was garbage she then wanted to know why I worked with her. What had a curative effect was my conveying to her that I liked working with garbage.

A. Mrs. R is telling us about another level of the treatment and it is most important. The reason why the person who feels like garbage gets better is because eventually she comes to believe that she has succeeded in convincing the analyst that she is garbage and then she wonders why the analyst keeps her. The realization comes that she cannot shake off the analyst by creating hopelessness. Even when the analyst feels hopeless she sticks with the patient and, therefore, the patient too is stuck with the analyst. They are stuck intra-psychically with one another and the self has an object.

Q. Why put borderlines on the couch?

A. To answer that let us consider how we establish the analytic relationship and what we are communicating to the patient. We respond to the patient's first telephone call requesting treatment by asking, "Who referred you?" If an appointment is arranged, we ask the patient what brings him here. If patient and analyst agree to work together, the analyst maintains a listening posture. Modern analytic patients frequently begin with one session weekly. If, during the initial session, the patient's problems are deemed amenable to analytic treatment, the patient is invited to take the couch. Frequency of sessions may be determined by the severity of the conflict, by an inability to pay for greater frequency, by the lability of defense, or by the patient or analyst's intolerance for greater frequency. It is desirable to start once weekly and if the patient is demonstrating a desire for greater frequency, to add sessions over a period of months. We will thus establish what degree of contact the ego of the patient can tolerate. The specific frequency that results in the desired tension level is the frequency to maintain. I don't want to give the impression that analysis conducted once weekly is optimal for all. Each case is studied for the optimal frequency. Analytic candidates may begin analysis once weekly; however, it is desirable to expose the analytic candidate to more intensive frequencies for some period of the training analysis. The couch is ideal for analysis. If regression threatens to reach levels leading to somatic or psychotic levels, the analyst controls the regression by the amount of talking she engages in.

Q. Do you believe that some patients are not amenable to analytic treatment?

A. Yes, but not if the condition is psychologically reversible. If a patient is not accepted for analysis, it usually means that either I or the supervisee found that for our own reasons, we could not work with that particular person. In the same way some patients come in, feel we are wrong for them and cannot work with us. I have seen students take patients that almost any experienced analyst would refuse and achieve remarkable results.

Q. Why was there opposition to putting some patients on the couch?

A. When I was in training, the theory was that to put a severely regressed patient on the couch is to invite further regression. Since then we have learned that regression is controlled by the amount of and type of communication from the analyst. Experimenting with control of communication began in the forties at the Jewish Board of Guardians where social workers were being trained to treat borderline children and their families in psychoanalytic psychotherapy. Dr. Hyman Spotnitz, a consulting psychiatrist on the borderline project, trained social workers in the analytic approach and they began to experiment with the couch.

Talking is used to maintain the proper level of regression. Our goal with the patient is to help him reach into his conflicts at the rate at which defense and emotion can be verbalized. We now have a body of research on how we have fared in this experiment dating back to the forties. As early as the fifties, psychologists, psychiatrists and others were joining social workers in this mode. It has become clear that each therapist must decide if she is comfortable working with a severely disturbed patient on the couch. If the analyst is willing and the patient does not regress to a level that the analyst feels is wrong for the treatment the choice was a wise one.

It helps to visualize the patient in the ways we have discussed. The approach will be different to the withdrawn patient than to the terrified patient, and still different with the omnipotent patient in a symbiosis with the analyst, and yet another to the self- or object attacking patient.

Q. I had a patient who in the first session took one look at the couch and said you're not going to put me on that. I asked why not, and he said, "I can't relate when I'm on a couch. I don't like it and I don't want to use it."

A. If a patient doesn't want to go on the couch I see no reason to insist and certainly not until we understand more about the patient's insistence. It is a resistance to the analyst's prescription, but in analysis we don't go against a resistance—that resistance may be the bulwark of the ego. In the process of getting to under-

stand the resistance we learn about the patient's emotional conflicts. Progress in analysis takes place around the resolution of a particular resistance. The resolution is a confirmation of a successful bit of analysis. I remember a woman, a successful woman, in every way functional except when she revealed what was hidden, her paranoia. One of the things she said to me when she get on the couch was that she had the feeling I was sitting behind her with an axe and if she used one wrong word, the axe was going to fall. However, she wanted to use the couch. She reported a memory of a swimming pool incident. She was in a swimming pool as a child enjoying herself, bobbing up and down, when suddenly her head connected with her mother's jaw and it broke off one of her mother's teeth. That story pretty much fit her expectations in relationships.

Q. I had a very cooperative patient until six months ago. He asked me for help with his daughter whom he was afraid of subjecting to the same kind of life he had lived. He had been brutalized by his father. He brought her and his wife to a session. The mother announced that the daughter wanted to speak to me privately about a problem and asked if that was all right? The girl came in, said "I'm six. I forgot." I noticed she had a large scratch on her face. I asked her if there was anything else she wanted to say. She said, "No." I asked if she wanted the family to come in now. She said, "Yes." The whole family entered my office. The father seemed agitated and said, "You have to let me use your phone." His wife said, "You don't have to make the call until 8:00. It's 7:30 now." Then the mother began to talk of the scratch on the child's face. With that the father picked himself up, grabbed his coat, and ran out. Three or four minutes later he reappeared and said he was ready to listen. A minute or two later he picked up his coat and said, "Let's go." To me he said, "We're all leaving. You better apologize to me right now." When I asked why, he said, "If you don't know, then you can't treat my family." This was the last session of the month, so I asked him if he planned to pay me. He said that I could send him a bill, then he left. He did not return. When I called him he said, "Look, if you had let me use your phone I would still be your patient."

A. The patient demonstrated how he could act the tyrannical father that he feared being, but he didn't want his wife talking about how he hurt his daughter. He assumed the analyst, too, was a tyrant and would not let him use the telephone—the question of when we would allow a patient the use of our telephone is another question. His only resort was to threaten. The way he put it was either you let me use the phone now or. . . . We can see that the emotional response of this patient was exaggerated and re-

vealed his repetitive pattern. This reminds me of the patient who required a handshake each session in order to stay connected to the analyst.

Q. Isn't it possible the therapist was combative with the patient?

A. Yes, of course, each analyst and therapist has an unconscious, and that unconscious will be responsive to the patient's unconscious. Subtle negative communications may be the response of the analyst to the provocative behavior of a patient. How the analyst deals with induced emotional states will determine the therapeutic effect of the analytic exchange. The analyst learns about the patient's patterns by observing his own emotional responses to the patient. He has time to reflect on repetitive reactions and to prevent untimely communication of non-therapeutic responses. It is because both our positive and negative reactions to a patient need scrutiny that we limit the therapeutic interaction to talk until the dynamics are clear. That means that if the patient wants to use the telephone, eat, drink or smoke and we have an impulse to permit it, caution is advised. Generally when the analyst gets embroiled in meeting requests, he puts obstacles in the way of understanding what the patient is showing him through these requests. In the same way, once the patient leaves the treatment, there is no pursuit, no bills. The only way a patient can have a relationship is by coming to the sessions.

Q. Can you explain why you don't bill the patient or dun him for delinquent fees?

A. If a person is not going to be in treatment with me, I prefer he have his victory, that he punish me symbolically, rather than hurt or torture himself or come to shoot me.

Q. I had a patient having an extramarital affair who did not want to give it up, so left the treatment and did not pay.

A. Going after the fee conveys symbolically that the analyst is more interested in a relationship than the patient is, or, in getting his way. Analysis is the art of reading symbolic messages. The patient doesn't come and give us a coherent story of his conflicts. Rather, he puts the conflicts on display. Freud likened analysis to a play pen.

Q. With that father who did not want to do to his daughter what had been done to him, what treatment modality would you use. Family sessions as the therapist did?

A. I have tended to work in the individual mode. However, in cases such as this, we have a man who might not have sought treatment if he were not concerned about his daughter's welfare.

Despite his need for individual treatment, I would invite this man to bring in any family members with whom he wanted to discuss his fears of brutality.

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The first interview in modern psychoanalysis

Evelyn Liegner

Introduction by William Sharp

Evelyn Liegner was a leading figure in the history of modern psychoanalysis, probably most well known for her book *The Hate That Cures* (2011). This article became a chapter in that book and is significant to me for both its conceptualization of the evolution of psychoanalysis and its ability to capture an almost "how-to" attitude that I have come to enjoy about much modern analytic writing on technique. Going back to this piece is grounding, not only when I am about to meet a new patient, but also when dealing with long-term patients overstimulated by some shift in treatment. It is one that I recommend for my supervisees, as you don't need a lot of psychoanalytic-literature jargon to glean something from it.

Liegner mentions the way Freud's statements have been reified by certain practitioners, even though there is evidence of Freud often amending and even disregarding his own stated suggestions. I read Liegner as proposing not so much rules as goals and guides for our exploratory questions. She is making suggestions. From her, I infer, "Keep in mind there is always a narcissistic and psychotic core; avoid questions that might be ego injuries; invite the patient to say more, and accept it when they do say more, or show in action what they can't say in words." She reminds us of Spotnitz's pronouncement that we should avoid blaming the

patient for "failures," as it is at least as likely that the analyst's limitations are getting in the way. I find myself breathing a sigh of relief as I am reminded that the analyst has a character, too, and the "blank slate" or impersonal analyst is a fallacy.

Liegner stresses that we learn about the patient from the very first contact, even before we meet in the first session. Does the patient have availability and flexibility, or is their schedule so tight (a symptom of something) that an intake cannot even be scheduled? Does that also say something about his/her willingness (or ambivalence) to engage in treatment? To get into my office, you need a code at the door. I instruct patients on the phone and/or via email to press "#" and then the four-digit code, but I am always ready to answer a frantic or frustrated call at the new patient's hour when they "can't get in," most often because they forget to hit "#". These enactments, their responses to early frustrations, all begin to tell me something of the character of the patient. I appreciate how Liegner is inviting us to meet the character who is our patient. Who else could they be? And who else would we expect (or want) to "show up?"

Dr. Liegner died April 5, 2020. but it would be interesting to hear how she might have thought about the state of treatment due to the COVID-19 pandemic. How can we take what she thought about first contacts and sessions, and apply them to working online? Are there different kinds of facilitating responses in a FaceTime and Zoom world? I am unaware of how Freud responded to the flu epidemic of 1918, but surely he had to make accommodations. I find rereading Liegner that there is some direction we can confidently infer: 1) Follow the contact function; if a patient is ambivalent about starting or continuing to work online, explore the stated resistance. 2) Expect some regression—the analytic practitioner may find the need to return to object oriented questions even if they had progressed from there, as anyone can find themselves more fragile when tension states are no longer optimal for their character. 3) Continue to trust your feelings—objective or subjective, they have important information for the analyst. As I cannot see improving on Liegner's own concluding remark, let me end with that as my 4) "Ultimately, it is only the patient who can validate the psychoanalytic practice, from which may come a unified theory (p. 66)."

38 The first interview in modern psychoanalysis*

An intial contact and interview between patient and analyst in modern analysis differs in many ways from an initial contact and interview in classical psychoanalysis. Some similarities also exist. In the following discussion these differences and similarities in theory and practice will be highlighted and a summary of a modern psychoanalytic first interview will be presented as an illustration.

The first rules laid out by Freud (1912, 1913) for practicing analysts were based on his conviction that to take on the treatment of the schizophrenias or narcissistic disorders was a gross error of judgment. He believed that an analyst who undertakes to treat such cases "has committed a practical error; he has been responsbile for wasted expenditure and has discredited his method of treatment. He cannot fulfill his promise of cure." A less pessimistic view of the psychoanalytic treatment of severe mental disorders is now emerging (Searles, 1965; Arieti, 1974).

While the definition of psychoanalysis as "any line of investigation which takes transference and resistance as the starting point of its work" remains the same, the rules and advice of classical analysis, as gleaned from Freud's early papers, differ in several important instances from those of the present-day modern analyst. The following are some of the ideas expounded by Freud in his early writings:

1. "Select only suitable patients." (This precludes, in addition to the ones mentioned previously, patients who have been treated by other modalities, relatives, and those with whom the analyst may have had discussions about treatment.)

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2. "Distrust and do not expect the return of any patient who puts off treatment."
3. "The treatment of friends and relatives guarantees the loss of friendship."
4. "Warn the patient that his favorable first impression of the analyst will be shattered."
5. "Tell him that his attitudes are his symptoms."
6. "Adhere rigidly to the principle of leasing a definite hour."
7. "See patients six times per week."
8. "It is a duty to let the patient know of the difficulties and sacrifices involved in treatment."
9. "The analyst forthrightly states the price he puts on his time."
10. "Give no free treatment—make no exceptions."
11. "Adhere firmly to the requirement of reclining on the couch."
12. "[The patient is to] say whatever comes to mind. Never censor."
13. "Remind the patient he has made a promise of absolute honesty."
14. "Refuse permission to deviate from any rules."
15. "Use properly timed interpretations as the method for resolution of resistances."

Although the ideas stated above became "rules" to many later psychoanalysts, the development from orthodox to classical to modern psychoanalysis was presaged by Freud. It is well documented that Freud was constantly breaking, modifying, and altering his theoretical views up until the time of his death. However, it is of historical interest to contrast the earliest rules regarding the onset of treatment with "suitable" patients to the current views of modern psychoanalysis.

Freud (1913) stated that he was "collecting together for the use of the practicing analyst some rules for the opening of

treatment." He goes on to state that he brings them forward as "recommendations" without claiming any unconditional acceptance for them.

The exceptional diversity in the mental constellations concerned, the plasticity of all mental processes, and the great number of the determining factors involved prevent the formulation of a stereotyped technique, and also bring it about that a course of action, ordinarily legitimate, may be at times ineffective while one which is usually erroneous may occasionally lead to the desired end.

The following are representative of the rules and recommendations of the modern analyst (Spotnitz, 1969):

1. Any patient with a psychologically reversible condition is considered treatable, at least theoretically.
2. Ask the patient when he would like to come. If the time the patient asks for is available, it should be given. If the patient rejects several alternative times, he may feel ambivalent about treatment and might be asked to call again.
3. Does the patient know where the analyst's office is? Ask him to repeat the time and address. Ask the patient to call again if he becomes uncertain later.
4. Once in the office the patient might be asked the following questions: How did the patient get to the analyst? With what problem does he want help? How frequently does he want to come? How much does he want to pay? When would he like to begin?
5. Do not volunteer information about possible duration, emotional difficulties or anticipated results of treatment. Do not promise a successful outcome.
6. Do not volunteer information about your credentials.
7. Do not ask the patient to free associate, but rather to say whatever he wants to say. There is no mention of honesty.
8. Use the couch if the patient is willing. Otherwise work to understand and resolve his resistance to the couch so that he can be helped to use it.

9. Use only those interventions designed to help the patient to stay in treatment.

Although Freud discussed the beginning of treatment, he made no reference to the manner in which the patient first makes emotional contact. Today we are aware that the analyst's response to the patient's first contact is essential in determining whether a treatment contract can be attained. The manner in which the patient contacts the analyst, the contact function, is a guide to understanding what the patient needs. It helps the analyst determine what questions he may ask with genuine interest. Object-oriented questions, those that avoid thoughts and feelings about the self, are the preferred response when it seems likely that the patient has a fragile ego. Ego-oriented questions, questions relating to the patient's thoughts, feelings, and wishes, are often disturbing to him and experienced as attacks. Object-oriented questions avoid relating to the ego of the patient by referring to the analyst and the external world.

In the sample interview which is presented later in this paper, the patient makes no emotional contact with the analyst. From this the analyst may assume a narcissistic state. In such situations, the analyst educates the patient to make contact by asking a few questions that are object-oriented. This approach is especially relevant for patients whom Freud considered untreatable—those suffering from severe narcissistic disorders.*

The first contact may come by telephone, letter, an unexpected appearance at the office, or indirectly, through a relative. The analyst often has to facilitate the arrival of severely disturbed patients at the office.

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* Narcissistic disorders encompass a range of mental and physical disturbances which have fixations in the oral and anal phases of development. Increasingly, clinicians are including as possible causes, intrauterine influences, along with genetic and constitutional ones. Autism, schizophrenia, psychosomatic conditions, addiction syndromes and character disorders, as well as borderline conditions, fall into this category. In contrast, psychoneurotic disturbances relate to conflicts of the oedipal phase of development.

In the first interview, the analyst does not know his patient. Until an agreement has been reached, joining techniques are not recommended. Joining techniques refer to a variety of communications that have a maturational effect. They help the patient function cooperatively in the treatment session by removing the immediate obstacles to communication. They are used to deal with resistances (what Freud referred to as "stone-wall" resistances) that do not respond to interpretations.

During the first interview the patient's functioning is observed and tentative diagnosis is made. Medical reports are requested if indicated. No routine history need be elicited. An initial interview can be considered ended when a verbal agreement is reached. This may take several sessions.

There is enormous richness, variety, and depth in the initiation of a therapeutic relationship based on patient and analyst dynamics, character, and personality. It can only be hinted at by the following brief excerpts. Responses which facilitate communication are based on the analyst's feelings, knowledge, and judgment. For example:

Patient: My friend told me you helped him. Can you help me? I'm very unhappy.

Nonfacilitating: Yes. I have helped him and am sure I can help you, too.

Facilitating: What is the source of your unhappiness?

Patient: Dr. X. recommended me to you. I could not afford his fee. How much do you charge?

Nonfacilitating: My fee is … I'm sure we can work something out.

Facilitating: How much would you like to pay? How often would you like to come?

Patient: What are your credentials?

Nonfacilitating: I am a graduate of…

Facilitating: What would that information tell you?

Telephone Call: My wife told me to call you. I don't believe in this stuff. She should see you.

Nonfacilitating: Why don't you make an appointment and we can talk about it?

Facilitating: Why not bring your wife in or have her call?

Patient: I'm here now but I have no problems.

Nonfacilitating: Well, that's a problem. Everybody has problems.

Facilitating: Who suggested you come here? Is there anything I can do for you right now?

Patient: I am looking for the right analyst but have not found one yet. You have been highly recommended to me.

Nonfacilitating: I am sure I can help you. Let me give you an appointment.

Facilitating: Would you like an appointment to determine whether we can work together?

Patient: The school (parents, court, etc.) says I have to be here or I will be sent away. That's the only reason I came.

Nonfacilitating: That is not a good enough reason for being here. You will have to want treatment for yourself.

Facilitating: Now that you're here what should we do about the situation? I am not so much concerned with what the school wants but with what you want.

Letter: The patient sends a letter requesting an appointment, gives some information about himself, and asks the analyst to call him to arrange for an appointment.

Nonfacilitating: The analyst telephones the patient, thanks him for the letter and arranges an appointment.

Facilitating: The analyst sends a letter in return, thanks the patient for the information, asks him to call and gives a telephone number and the times when he is available to receive calls.

The following is a summary of a modern psychoanalytic first interview, illustrating some of the modern analyst's initial interview techniques:

I received a telephone call from Mrs. B. in which she stated that she had been referred to me by her former analyst and would like to start analysis. She volunteered that she was available at any time and knew where I was located. She sounded friendly, and the arrangements were readily made and kept. I was struck by, and felt somewhat suspicious of the "mature" manner in which she spoke, the absence of any uncertainty, and the clarity of her request. As a rule, patients initially show some hesitancy

and anxiety on making contact with a new analyst. I speculated, however, that her manner may have been the result of her prior treatment experience.

Mrs. B. arrived exactly on time, greeted me, sat down, and began to talk volubly. She presented herself as intelligent, articulate, and well composed. She was attractive and appeared younger than her stated age. She immediately informed me of her familiarity with analysis, having been in treatment with her former analyst for eight years. She described her current life situation in an animated way, characterizing herself as skillful, competent, and well organized. She talked on and on about her past history, her previous analyst and her life situation. She seemed totally oblivious of me—almost as if she were talking to herself.

Mrs. B. was full of praise for her previous analyst; her face glowed as she spoke of him. She had contacted me on his recommendation that she secure further analysis. She would have preferred to return to him, but he strongly advised that she work with me. She was following his recommendation since there were some practical, financial, and geographic difficulties in seeing him and my office was convenient for her. I immediately felt on guard. A patient who had been as satisfied with an analyst as she indicated would not be so cheerfully willing to make a change; she would, in fact, have some feelings of resentment at being rejected.

During this initial interview she made no contact with me, but simply continued her monologue until, at what seemed a suitable moment, I asked her what situation had led her former analyst to recommend further analysis. Her voice became suddenly shrill as she began to tell of her chronic dissatisfaction with her husband and her overwhelming determination to secure the divorce she had wanted from the beginning of her marriage.

Her composure gave way and an angry, frustrated woman emerged. A divorce, she emphasized, was her only goal in seeking treatment at this time. A stream of invective against her husband poured forth:

> I must get a divorce. My husband wants to kill me. He is committing crimes. This marriage must be ended. He is doing terrible

> things. One part of his mind doesn't know what the other part is doing. He is following me around. I don't feel safe on my job. He hires people to spy on me. He is crazy.

I felt uncomfortable and confused, and I recalled my skepticism at the time of her telephone call. My initial thought that I was dealing with a well-integrated woman with a marital conflict changed. Her emotional lability seemed bizarre. A warning signal had been triggered in me, and I had the feeling that I might be in the presence of psychosis. Nevertheless, I felt a desire to work with her.

When I asked Mrs. B. what problem she would like me to help her with right now, her tone changed and she plaintively and beseechingly asked me whether I could help her get a divorce. Because of her apparently severe emotional disturbance, I wondered to myself, but did not ask her directly, why she needed my help rather than a lawyer's. I asked if she would be willing to enter an exploratory period of treatment to see whether we could ascertain what had interfered and prevented her from dissolving her unsatisfactory marriage. This would also give her the opportunity to determine whether we could work cooperatively together and whether I was the right analyst for her. It would also give me the opportunity to better understand her situation and to know whether I could be of help to her. Following these communications, she was calm and controlled.

She readily acquiesced. When would she like to begin, how often would she like to come, and how much would she like to pay were the only other questions asked in this interview. She chose to begin immediately on a weekly basis and offered me a fee that I normally would charge. I considered it prognostically favorable that her responses were in keeping with my own thoughts, wishes and needs. She had no objections to the use of the couch. My tentative diagnosis, based on my observations, knowledge and the feelings induced in me, was paranoid schizophrenia.

Freud (1913) recommended a provisional period of treatment for the purpose of diagnosing the patient to determine his suitability for analysis as then "one is spared the distress of an unsuccessful attempt at cure." Thus the exploratory period was also an elimi-

nation procedure for patients whom he felt he could not cure. The modern analyst recommends an exploratory period for the purpose of better understanding the patient, giving the patient the feeling that he has the right to eliminate the analyst if he feels the analyst cannot help him, and for both to decide whether they want to work together. Thus, for the modern analyst only the conviction that this particular patient would be more effectively treated by someone else would be considered a reason for not working toward a treatment contract.

In the first sessions, Freud told the patient his analytic rules, including the need for daily sessions and the demand for honesty. He gave lengthy instructions on how to free associate and would challenge a patient's inability to produce material, cautioning him that he is resisting. It can be assumed that a first interview was a test of ego strength.

In contrast, the assessment of the ego of the patient during the interview determines the modern psychoanalyst's communications. Mrs. B. was asked primarily object-oriented questions. At no time was she asked to talk about what she was thinking or feeling. It is assumed by modern psychoanalysts that most patients have some narcissistic problems and are to be responded to on that basis to guarantee against further narcissistic injury and ego attack. Thus caution was exercised in the opening interview with Mrs. B. She was asked what brought her there and what she wanted from treatment.

Freud (1913) considered feelings undesirable in the analyst and believed that they needed to be analyzed away when they extended beyond mildly positive and helpful ones. Initially he used as his model the surgeon "who puts aside all his own feelings, including that of human sympathy. The justification for the coldness in feeling in the analyst is that it is the condition which brings the greatest advantage to both persons involved" (Freud, 1912). In contrast, it was the feelings induced in me by the patient during the first telephone contact and interview that gave me the clue that I was dealing with a very disturbed person who would require careful handling.

I did indicate the desirability of using the couch, but if she had objected I would have been prepared to work face to face until

I resolved this resistance. I asked her to say whatever she wanted to say rather than to free associate. The purpose of this is to prevent too rapid a regression, which can readily occur when patients with ego fragmentation or already partially decompensated states are asked to free associate. Such patients may feel threatened and overwhelmed by such a request and are reassured when asked to talk about anything they wish.

I consider the treatment process to have begun from the first telephone contact. I was alert to any evidence of transference, countertransference, or resistance in myself as well as transference and resistance in the patient.

I elicited no history. I listened to what the patient said voluntarily and asked only those questions which could lead to a treatment contract. At no times were conditions of treatment spelled out. Minimal information was offered. My attitude was one of interested study of what she communicated verbally and nonverbally. I assumed full responsibility for creating the conditions that would make it possible for analytic work to be accomplished. I did not require cooperation on the part of the patient.

A basic philosophical tenet of modern analysis (and a fundamental difference from classical analysis) is that unsuccessful treatment or inability to work out a therapeutic alliance is not considered the failure of the patient, but evidence that the analyst did not have the skills necessary to accomplish the job. This position is acknowledged regardless of whether the analyst is sufficiently trained and analyzed, whether he wants to work with the patient, or whether the present state of scientific knowledge is adequate. Since many patients suffer from a deeply held conviction that their difficulties stem from some basic deficiency in themselves, this attitude on the part of the analyst is helpful for effective work with them.

In order to facilitate entry into treatment of the more disturbed patient, the analyst responds to the manner in which the patient presents his characteristic narcissistic defense. The narcissistic defense is, in essence, predicated on the concept that frustration-aggression experienced in the first few years of life is released against the psychic apparatus of one's own mind and

body as a defense against the danger of acting on impulses that might destroy the frustrating object. A full discussion of this may be found in H. Spotnitz, *Modern Psychoanalysis of the Schizophrenic Patient.*

It is important to keep in mind that narcissistic patients are unconsciously terrified of their potential for violence, and the prospect of being exposed to further hurt, rejection and humiliation. Their deeply held emotional conviction that there is something seriously wrong with them is not conducive to a commitment for treatment. Many are negatively suggestible and defiant. These mechanisms have helped them to survive. Often the compelling factor which precipitates a contact is unbearable suffering and a wish for some relief. The expectation and prospect for even further suffering does not enhance their wish for treatment. When the analyst comprehends the narcissistic defense, he is able to make interventions that stir within the patient a vague hope that he will not be subject to further narcissistic injury or control and that the analyst is there for his benefit.

In modern analysis rules are generally spelled out as the occasion arises rather than in advance. Spelling out rules conveys the unconscious communication that the analyst expects a transgression against them, and the patient may feel the need to comply in order not to disappoint the analyst. It is recommended, therefore, that only suggestions that facilitate the onset of treatment be given. Thus, policies about lateness, payments for broken appointments, smoking and eating are preferably dealt with as they emerge in the treatment process.

In my opinion, an analyst should not attempt treatment with a patient with whom he does not wish to work unless he can work this problem through in his own analysis. It is important for the patient to get the feeling that his analyst is genuinely interested in helping him, regardless of the analyst's verbal communication. Narcissistic patients are acutely sensitive to what other people are feeling. If the analyst is not genuinely interested in the patient, it is preferable for the analyst to take the position that he is not the right analyst and that he cannot be helpful. This may be stated as the analyst's deficiency, not the patient's,

e.g., “I am not adequate to deal with the problem you are presenting,” or, “My ability does not seem to make it possible for me to give you the help you need.”

A special problem arises when patients indicate that they have been in treatment with someone whom they find unsatisfactory. If the treatment has been terminated, it is advisable to find out the patient’s idea of what the problem was. This often gives an important clue to the proper prescription for the patient. If the patient is currently in treatment, it is preferable for him to get agreement from his other analyst for a consultation. If the other analyst feels threatened, resentful or unwilling to let the patient go, that treatment should be terminated before a new one is begun. This becomes the responsibility of the patient. With both analysts’ agreement, concurrent analyses may be conducted. Modern psychoanalysis accepts the idea that such multiple therapies can be beneficial to all concerned.

The modern psychoanalytic approach to facilitating entry into treatment for all patients has been described. Expanding knowledge and a patient population increasingly dominated by narcissistic problems have led to elaboration and modification of Freud’s recommendations, facilitating the entry into treatment of patients formerly considered untreatable.

In contrast to the earliest Freudian practices, from the very first emotional contact, the modern psychoanalyst’s theoretical considerations are secondary to the primary objective of curing patients. While some practitioners hold the view that practice emanates from theory, the modern analyst’s functioning is based on each patient’s individual configuration. Ultimately, it is only the patient who can validate the psychoanalytic practice, from which may come a unified theory.

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Narcissistic transference: The product of overlapping self and object fields

Benjamin D. Margolis

Introduction by Uta Gosmann

When years ago in the early stages of my training we were reading Spotnitz's *Modern Psychoanalysis of the Schizophrenic Patient*, I asked the instructor why she was "applying" modern analytic techniques to us in her process-oriented class, even though we were not schizophrenic. Today, the patients I see in my private practice, too, do not tend to be schizophrenic. On the contrary, in the world of mental health in 2020, most of the patients who seek out a psychoanalyst, in my experience, tend to be reality-oriented, self-reflective, educated, articulate, and cooperative. Yet I find it indispensable to return to the modern analytic literature and immerse myself in texts written specifically for the psychoanalytic treatment of patients suffering from psychotic mental processes. Perhaps one day somebody will write the book "Modern Psychoanalysis of the Non-Schizophrenic Patient." For now, as an introduction to Benjamin Margolis's paper, let me present a few thoughts on why the "narcissistic transference" and the "overlapping self and object fields" are relevant to *any* analysis.

Among modern analytic writers, Margolis is perhaps Spotnitz's foremost explicator and elaborator. He provides clarity and detail for difficult concepts and unconscious dynamics. I like to reread

his paper “Narcissistic Transference: The Product of Overlapping Self and Object Fields” (1994), because it helps me refocus my attention on what is at stake in psychoanalytic work and how it can succeed.

Margolis (with Spotnitz) offers us a theoretical framework for understanding the origin and causes of the earliest forms of self-hatred; and he presents us with a means, the narcissistic transference, for their resolution. In the first six years of life, the child works on separation from the mother more arduously than at any other time. The most tangible culmination of this work is the oedipal crisis. But invariably, separation turns into a marred process long before that, because the child’s ego becomes tainted by negative introjections. This is true for any person and not only for those who will develop schizophrenia later in life. Margolis sees the origin of self-hatred in the experience of a hostile mother whose hostility the child introjects and comes to view as his own. I believe the origin lies in the sense of enfeeblement that inevitably accompanies our separation. The “fall from universal fullness” or *Allfülle,* as Lou Andreas-Salomé calls it, makes us resent the person we separate from, and we turn the resentment against ourselves. Any analysis that does not reach this core of self-directed aggression is not complete, and it can surface and be worked through in the narcissistic transference.

If the resolution of self-hatred is one of the most important goals of analysis, it is closely followed by the need to strengthen a sense of self. Margolis describes how the indistinct boundaries between self and other in early life lead to a kind of flooding of the child’s psyche with otherness and result in “the child’s ego . . . encompass[ing] the internalized representations of all the personae of his narcissistic period” (p. 140). The narcissistic transference allows for the projection of these introjects onto the analyst and their gradual sorting out.

The narcissistic transference has tremendous potential but is difficult to work with. Even when negative, it implies great closeness between patient and analyst. It feels intense. The analyst needs to be able to tolerate the blurring of the boundaries between self and other. She is an active participant and cannot comfortably recede to an outside position, from which she may offer interpretations about the patient’s involvement with other people. If we can allow the neurotic patient to regress to a less differentiated state, the momentary overlapping of self and object field becomes the royal road to the patient’s unconscious. We leave the terrain of a purely intellectual or “insight-oriented” exercise and arrive in the midst of an emotionally transformative experience.

This deepening of psychoanalytic theory and technique, as Margolis describes it in this paper, was derived from expanding psychoanalytic treatment to pre-oedipal patients but benefits all analysands.

Narcissistic transference: The product of overlapping self and object fields*

The concept

Freud (1905) regarded transference as one of the two pillars of psychoanalysis, the other being resistance. In his metaphor, transferences are "new editions or facsimiles" of old emotional experiences, and "they replace some earlier person by the person of the physician." In a similar vein, Greenson (1967) defines transference as "the experience of feelings to a person which do not befit that person and which actually apply to another. Essentially, a person in the present is reacted to as though he were a person in the past." Until recent times in clinical theory, "the past" was understood to refer to the patient's oedipal period and the "earlier person" to a significant object of that period whose characteristics the patient now attributes to the analyst.

The ego of the oedipal child is relatively advanced in terms of function and identity. Self and object, child and parent, are perceived by the child as separate entities. When this situation is later replicated in the transference, the patient who is fixated at the oedipal period sees the analyst as a clearly delineated object who represents an earlier well-defined parental figure, both differentiated from the patient's self, past and present. Thus, for

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example, when such a patient accuses the analyst of being sly and deceptive, he is displacing onto him his impression of an *imago* of his one-time oedipal period.

The narcissistic patient differs from this picture. The phase at which he is fixated marks a level of development in which self and object are commingled in varying degrees. *I* and *you* are not separate entities. It may fairly be said of this state that what is mine is yours and yours mine, including traits, attitudes and emotional dispositions. If we transpose this situation into the analytic framework and consider how this affects the transference, we are obliged to conclude that the transference of the preoedipal patient differs radically from that of the oedipal patient. When the preoedipal patient ascribes to his analyst an attitude which he is transferring from a figure in early life, e.g., "You are hostile," several possible meanings present themselves. 1) He experienced his mother as hostile, introjected her hostility and made it his own, and now reprojects it on the analyst. 2) He was himself hostile and projected the hostility first on his mother and now on the analyst. 3) It was an attitude ascribed to the patient by objects in his early life and accepted by him about himself. The mother regarded the patient as being hostile, a judgment about himself which he introjected and made his own. He now reprojects onto the analyst the trait of hostility, which he has always accepted as characteristic of himself. The potential for transference meanings is limitless, fostered by the vicissitudes of early maturational history.

We distinguish the transference of the preoedipal patient from that of the oedipal patient by calling the former narcissistic transference and the letter object transference. In operational terms, this means that the oedipal patient transfers the images of distinctive objects of his oedipal period onto the analyst, whereas the preoedipal patient transfers onto the analyst the fuzzy and ambiguous images of his narcissistic period. These latter images may represent assorted pcrsonac of that period, such as the patient himself as a young child, various objects (mainly parental) in his environment, and confused self-object configurations. The blurring of boundaries between self and object at that early time and their consequent overlap results in the child's embodying in his own psyche the attitudes of the

ministering parental figures. The child's ego may therefore be said to encompass the internalized representations of all the personac of his narcissistic period. Later on in the analysis, when the patient speaks about the analyst, he may be transferring onto him the attributes and attitudes of any number of these figures, but he ultimately speaks of himself. In building the narcissistic transference and cliciting the patient's picture of the analyst, we are actually cliciting his picture of himself. Thus, for example, should the preoedipal patient, like his oedipal counterpart described above, see the analyst as sly and deceptive, he is expressing an attitude about himself. In standard analytic parlance, this is called a projected image, which may serve as a shorthand reference to it. It is therapeutically useful, however, to conceive of the narcissistic transference less as the function of operant defensive mechanisms, such as projection, and more as the product of overlapping self and object fields.

Negative transference and implications for therapy

Understanding the difference between narcissistic and object transference provides us with a valuable insight into the treatment of the narcissistic as distinguished from the oedipal patient. When the oedipal patient ascribes an attitude to the analyst, the latter may make an interpretation based on object transference, e.g., "This is how your father appeared to you and how you felt about him." The patient had experienced the oedipal situation as a relatively mature person, with a command of language and secondary process thinking. The interpretation now offers him an insight into his unresolved ocdipal conflicts and how they affect his relationship with the environment. It makes a connection in his mind between his current transference feelings and the original ocdipal feelings by means of the spoken word, which is present in both situations. As a result, it enables him to evoke from the unconscious the hostile thoughts and feelings about his father and to liberate himself from the conflicts associated with them.

The therapy of the preoedipal disorders, on the other hand, differs from that of ocdipal disorders expressly with regard to

the use of interpretation. Language skills had not yet evolved to any appreciable degree in the early stages of development at which the preoedipal patient is fixated, nor had thoughts, feelings, and memories become associated with verbal expression. Events and feelings of that period are therefore largely inaccessible to secondary process thinking and verbalizing. Interpretations, offering intellectual explanations of the connection between the patient's transference feelings and his early childhood experiences, will only fall on deaf ears. They will evoke no countervailing memories of the past. To tell a restless, demanding, discontented preoedipal patient: "You were a colicky, distraught infant who remained inconsolable no matter how your mother tried to ease your distress," will have no constructive effect. It may even worsen the patient's condition and generate greater resistance since, unable to place the statement in any meaningful context, his immature ego may experience it as an attack.

The give and take between mother and child in the narcissistic phase is essentially emotional, and the patient-analyst transactions can have meaning for the patient only if they likewise take the form of emotional interchanges. The development of the narcissistic transference is thus an emotional process, not dependent on insight. The narcissistic transference is, in Spotnitz's (1969) words, "the patient's attempt to reveal the basic maturational needs for objects that were not met in the course of his development." The attachment of the impulses arising from these needs "to the present transference . . . makes it possible to liberate [the patient] from their pathological influence" (p. 139).

We are dealing with an individual who has remained maturationally stranded by virtue of his self-destructive narcissistic defense patterns. This entailed repressing his negative feelings against the mothering object and deploying them against his own ego, with unfavorable consequences for emotional growth. The narcissistic transference affords the patient an opportunity to reexperience those old feelings in the presence of an accepting object and provides the occasion for duplicating the struggle for survival that the patient conducted in the first years of life. It helps the patient throw off the conflicts and fixations of the narcissistic period by mobilizing his feelings, particu-

larly his angry feelings, and releasing them verbally toward the analyst, who stands surrogate to early objects. The release of feelings thus helps promote emotional growth. That is why the development of the narcissistic transference is heavily weighted on the side of negative transference, since that gives the patient latitude to verbalize such feelings. The successful mobilization and verbal release of aggression constitutes the key to the maturational unfolding of the narcissistic ego.

What keeps the patient's mobilized rage from spilling over and destroying the analyst? The analyst's technical skill is, of course, of utmost importance in maintaining control of the process and channeling the aggression into acceptable verbal expression. The analyst would be unable to accomplish this, however, were it not for the patient's libidinal drive which allies itself with the analyst, paradoxically in the form of resistance. When the analyst, in the interest of mobilizing the patient's aggression, makes a frustrating intervention, the patient becomes enraged and impelled to attack him. But his libidinal impulses intervene. In actuality, the patient craves closeness and affection from the analyst, akin to the way he once felt toward his mother. This libidinal investment in the analyst prompts the patient to shield him from the destructiveness of the patient's aggressive drive, as he once shielded the frustrating mother. Instead of turning his anger on the analyst, the patient protects the analyst and attacks himself. This is the narcissistic defense, which functions as the chief impediment in the analysis to the patient's expression of his aggressive feelings. It protects the analyst from attack by the patient, but it accomplishes this at the expense of offering overall resistance to the patient's expression of his aggressive feelings.

From this point of view, the narcissistic transference may be conceived as a reexperiencing by the patient of the patterning of the narcissistic defense, as well as its gradual loosening and fading away. The patient starts by protecting the analyst and attacking himself. He slowly learns to redirect the destructive impulsivity and give up his resistance to attacking the analyst. The narcissistic transference thus first highlights the pathological process of internalizing aggression, then reverses the process by helping the patient give up old pathways of discharge and exter-

nalize his destructive impulse, all in the minimally stimulative, non-threatening environment of the analysis. The spoken word serves as the unique vehicle for this purpose. The patient learns to say everything, to speak all his feelings without fear of acting on them or regressing out of control into psychosis. With the development of the narcissistic transference and the gradual release of aggression, the erotic drive, hitherto consumed in the struggle to check the aggressive drive, now becomes liberated and directs its energies toward objects. The patient grows increasingly cooperative, more freely expressing his feelings, thoughts, fantasies, and memories. The working alliance and object transference begin to take shape.

Building the narcissistic transference

With the beginning of therapy, the analyst strives to create a comfortable emotional climate, so that the patient will feel safe and wish to stay on in treatment. This is particularly crucial for the deeply narcissistic patient, who is often in treatment against his inclination. The analyst listens quietly, speaking only in response to the patient's contact. "By not providing the patient with excessive communication, the analyst can maintain the ego-syntonic environment necessary to master the patient's destructive impulses" (Spotnitz and Meadow, 1976).

The patient at first experiences the analyst as he experienced the object in the period in which he is fixated. This may be a very early objectless period, and the analyst does not exist emotionally at all for the patient. Strictly speaking, since no object existed for the patient in that period, we cannot speak of the transference at this point as related to objects. What is transferred is an original non-relatedness. The transference is not of an attitude *toward* the object but *about* the object, viz., that it does not exist. In this state, the patient remains enclosed in a shell of his own. Though he speaks, he makes no effort to establish contact with the analyst. Here is his initial resistance. The analyst soon recognizes that the patient will not make contact spontaneously. Having established this, the analyst's first steps are directed toward resolving the resistance by getting the patient to "see" him, to recognize his emotional presence.

He does this by asking object-oriented questions at intervals and later on by asking the patient what he wants the analyst to do with the material he has been presenting. When the patient begins to manifest awareness of the analyst by addressing him spontaneously, the development of the narcissistic transference may be said to be under way. The analyst, we observe, does not go about building the narcissistic transference directly. Instead, he helps the patient develop the ego function of making contact, which by its nature implies an object. With the analyst serving as object, contact functioning and narcissistic transference develop conjointly.

The foregoing description of the emergence of narcissistic transference through the resolution of resistance suggests one model (of several) of the process of transference building. 1. The patient is self-absorbed (resistance). 2. The analyst asks object-oriented questions (interventions). 3. The patient begins to manifest an awareness of the analyst by addressing him directly (resolution of resistance as evidenced by contact functioning). 4. This signals the beginning of the development of the narcissistic transference. As the analysis proceeds, other forms of resistance appear which require other types of intervention, notably, joining and mirroring. The aim, however, remains the same: to help the patient develop the narcissistic transference through the resolution of resistance, contact functioning and verbal communication.

It may be useful at this point to remind ourselves that the narcissistic transference serves only as a key—a vital one, to be sure—to the maturational unfolding of the preoedipal ego. The verbal interchanges of patient and analyst alternatively pose and resolve the patient's resistance to talking. This process is accompanied not only by the release of aggressive and positive feelings toward the analyst but also by the patient's burgeoning capacity to "say everything," to recount his life story, emotional, intellectual, circumstantial, past and present. The detailed accretion and sifting through, in this narrative, of fact and fantasy, of thought, dream, memory and striving that we call progressive communication, underwrites a parallel quickening of the long dormant potential for emotional growth. As the narcissistic transference develops, in brief, so does the pa-

tient's capacity to speak freely and in that way to accommodate ever larger segments of inner and outer reality.

The analyst's role

Who is the analyst? What role is assigned to him by the patient? The latter sees the analyst as he once saw his mother, so that the figure of the analyst is at first fleshed out as the bad mother representations. The patient had often experienced his mother as hostile, neglectful or indifferent. He had introjected into his own ego the parent representation with all its hostility, whereupon he came to view himself as equally hostile and to hate himself as his mother had hated him. If the narcissistic transference proceeds successfully, he now reprojects onto the analyst those same baleful parental feelings and his feelings about himself. It is the analyst who is now bad, as the parent was and as the patient is. The patient not only sees the analyst as hostile toward him, he actually strives to arouse in the analyst the same active hatred for the patient as the patient feels himself. From the early narcissistic configuration, in which the young child saw both parent and himself as hateful, the transference rearranges matters so that the patient and the analyst are now both perceived as hateful. Thus, when the narcissistic patient says to the analyst, "You despise me," he is saying, "You and I share an identical feeling of contempt, primarily for me, but also for you." The analyst abets the process by interventions that the patient experiences as frustrating, modified by occasional interventions experienced as gratifying, thereby replicating the emotional deprivation suffered by the patient in his narcissistic period. By analogy, the patient receives as meager an emotional "feeding" from the analyst as he did from his mother, while he develops the "bad mother" transference.

This is the genius of the narcissistic transference. It can reproduce within the analytic framework the overlapping self-object state that obtained in the period of early narcissism. In the person of the analyst, it provides the patient at one and the same time with a double of his own self-image and a replica of his bad mother figure. The patient can reexperience and work through

with the analyst the emotional traumas of his first years of life, freeing himself of the conflicts associated with them and proceeding with his psychological growth.

With the complete evolution of the narcissistic transference, equivalent to a fully developed symbiosis, the process of separation of self and object begins. The analyst gradually takes on for the patient the characteristics of the good (as well as, at times, bad) mother, and the patient, in transforming the analyst, transforms himself.

In schematic outline, the patient is helped to forsake his self-absorbed state and to permit the analyst to partner a common universe with him. The patient now sees the analyst as at once separate and part of himself, thus reenacting in the transference the symbiotic phase of his narcissistic development. All of the beginning and much of the middle phases of treatment are engaged in facilitating the evolution of an emotionally complete symbiotic union of patient and analyst, represented in the flowering of the narcissistic transference. From there, the patient proceeds in slow stages with the dissolution of the symbiotic bond and with emotional separation from the analyst, an enactment in the transference of unfinished business from early life. The process culminates in the fading of the narcissistic transference and the emergence of the object transference. Successful development of the narcissistic transference therefore carries within itself the logic of its own passing and its metamorphosis into object transference.

In view of the patient's fragile ego, his incapacity for verbal communication of feelings and his desperate clinging to the narcissistic defense, the burden of building the narcissistic transference falls upon the analyst. This differs from the analysis of the oedipal patient, where, with the preliminaries over and the analysis under way, the cooperative patient is expected to assume responsibility for developing the transference and establishing and maintaining the working alliance (Greenson, 1967). The narcissistic patient is, of course, far from cooperative, and the task of converting him into a stalwart of the working alliance is exactly what the building of the narcissistic transference concerns itself with. Since he is from the outset

incapable of, and even resistant to, this undertaking, it falls to the analyst to assume the responsibility for building the narcissistic transference. This is consistent with the general therapeutic approach of letting the patient feel accepted with all his ambivalences and resistances. His task, he is told, is merely to talk; everything else is left to the analyst. Should obstacles arise to impede the course of the analysis, the analyst takes the blame: "Why am I letting you feel so anxious and depressed?" "Why am I not helping you come on time?" "How come I'm doing such a poor job that you're getting colds and headaches?" This procedure not only spares the patient any tension over his resistance, simultaneously it draws the patient's attention to the analyst and in that way helps build the narcissistic transference.

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The problem of the bad-analyst feeling

Lawrence Epstein

Introduction by Barbara D'Amato

As a patient, an analyst, a supervisor and supervisee, I never consciously want to have the bad-analyst feeling. I don't want to think of my analyst(s) and supervisors as bad, nor do I want to be thought of as a bad analyst/supervisor by those that work with me. Most of all, I don't want to think of myself as a bad analyst—not ever. It arouses feelings of failure, fraud, incompetence and downright stupidity. Of course none of us aspires to that. Epstein in his paper explains why these feelings are inevitable, necessary and valuable when working with preverbal patients.

Spotnitz (1985) says that negative feelings when turned inward rather than appropriately put into words make us susceptible to a broad continuum of mental health issues and illnesses. Throughout his writings he provides myriad examples of the clinical efficacy of the analyst's appropriate use of such feelings, along with techniques in which to apply them. Epstein, in this paper, describes some of the specific reactions analysts can experience when they are flooded with the patient's "bad" feelings, and consequently become stuck, as they unconsciously direct those unverbalized feelings toward themselves, erroneously believing them to be entirely subjective. Epstein says about the patient, "The less conscious he is of his feelings the more covert his attack" (p. 36). Without supervision it can become nearly impossible for analysts

in such a quandary to extricate themselves from an ever deepening downward spiral, which then derails treatment progress.

Epstein directs much of his discussion toward the clinical treatment of borderline patients, but the feelings of resignation and self-loathing, or hostile feelings toward the patient, might arise in the treatment of any preverbal disorder. The analyst might then become filled with a sense of shame for having such feelings, and may begin to chastise herself for being unprofessional, poorly analyzed and perhaps in the wrong field. That these feelings are crucial to the treatment is the gift Epstein offers.

I include this paper on any syllabus in which I can rationalize its selection because of the reactions it elicits from students. In a classroom, I find that seasoned clinicians ardently appreciate Epstein's ideas because they have had more than a few patients who have taken them to this unenviable emotional situation. Even when students do not fully understand the how, why and when of applying any of the several modern analytic interventions that Epstein describes, they feel understood and encouraged to learn how to metabolize such dystonic sensations in themselves. His article is inspiring and yet quite down to earth. Every reading of it refreshes my belief that I can become a better analyst.

At certain junctures in the treatment of preoedipal patients the bad-analyst feeling is normal and must be worked with. I like that. Thank you, Larry Epstein.

The problem of the bad-analyst feeling*

I want to address a problem that I believe it is fair to say is shared by all psychoanalytic therapists. I refer to a complex of bad feelings that issues from a negative representation of the therapeutic self that inevitably and necessarily arises in our work with patients. This negative self-image and the feeling complex that

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issues from it I would call, respectively, the bad-analyst image and the bad-analyst feeling.

I have found problems with the bad-analyst feeling to prevail among all problems presented to me by students and supervisees. I have found such problems to prevail as well in supervision groups that I attend with my colleagues, and I regularly experience such feelings myself vis-à-vis my patients and my supervisees. In the latter case the term the bad-supervisor-feeling would be more accurate.

The bad-analyst feeling arises most frequently in connection with what we are likely to experience as treatment impasses. That is, such feelings may lead us to conclude that the treatment is at an impasse. In actual fact the therapy may or may not be at an impasse. Typically in supervision the therapist who presents such a situation is most often convinced, or near being convinced, that with respect to the patient being presented, sometimes with respect to his or her entire practice, he or she is a bad analyst.

The quality of the bad-analyst feeling will differ according to whether a given personality organization has been arrested at what Melanie Klein called the paranoid-schizoid level of development or whether the patient has reached what she called the depressive position, or what Winnicott has more aptly termed the capacity for concern. I shall limit my discussion to the countertransference problems we are likely to experience in relation to the first of these two categories of patients, those patients called difficult and, more specifically, these patients diagnosed as borderline.

Margaret Little has said that in working with borderline patients an analyst needs many psychoanalytic concepts. My own understanding has been illuminated by the contributions of Little (1951), Melanie Klein (1957), Racker (1957), Sullivan (1953), Winnicott (1949), Bion (1962), Searles (1965) and Spotnitz (1976, 1985). I have also found support for my understanding in recent publications of Robert Marshall (1982), Ogden (1982), and in the work of such modern analysts as Meadow (1977, 1978), Margolis (1978), Liegner (1980), Abrams (1976) and Ernsberger (1979).

I would like now to describe the behavior of those patients who are usually diagnosed as having a borderline personality organization as such behavior is manifested in the therapeutic interaction. Such patients usually seek treatment because their experience of living is dominated by feelings of chronic and intense dissatisfaction. Session after session is typically taken up with a barrage of repetitious complaints of being, in one way or another, mistreated, misunderstood, unappreciated, or neglected by the emotionally significant people in their lives.

They present massive resistances to what we think of as the normal give-and-take of the therapeutic interaction. Our efforts to engage their cooperation in making sense of their situations are met with impatience and with suspicion, especially at those times that our inquiry may touch upon their possible contributions to their interpersonal difficulties. Interpretations, more often than not, are experienced as inimical.

All interventions, in fact, are likely to be experienced as either bad, or as not good enough.

Sooner or later the therapy and the therapist become the target of the patient's dissatisfaction, which is expressed in one or more of the following ways. The patient may become angrily withholding, sometimes going so far as to affect a kind of mutism. The patient complains that he isn't getting anywhere, that we are too cold, or formal or uncaring. He denigrates our method, he talks about leaving treatment, about consulting a friend's therapist who is warm and caring, or he plans to try something different, like hypnosis, gestalt therapy, or one of the brief therapies, or even drug therapy.

He may apply intense pressure on us to, in one way or another, extend the limits of the setting, demanding extra time, or insistently claiming that he has a right to information about our personal lives. He may frequently telephone us at home, apparently desperate, and most times end up feeling unhelped and rejected no matter how long we remain on the phone. If we frustrate his efforts to reach us directly he may harass us via our telephone answering machine, taking up our tape with long and/or frequent messages.

Because of our perceived deficiencies and the apparent ongoing failure of the treatment, we may be repeatedly insulted and abused or threatened with suicide.

Turning now to the countertransference, let me elaborate on what we shall typically experience as the inevitable counterpart of such behavior. We can expect the countertransference experience to be so emotionally confusing, turbulent and stressful as to make it very difficult to sustain our therapeutic stance or to regain it once we have lost it.

Depending on a given patient's capacity to tolerate an awareness of his anger and hate, the assaults he makes on our feelings of goodness and competence will be delivered from higher or lower levels of consciousness. The less conscious he is of his feelings, the more covert his attacks. In these circumstances, we may be unable to see any direct connection between the patient's behavior and communications and whatever internal disturbances we may be experiencing. We may, for instance, experience a scrambling of our cognitive processes. The patient may be talking of things that we think should merit our interest, but in spite of our best efforts to concentrate, we may be unable to assimilate what he is saying. Our mind wanders capriciously, we may have to struggle to keep our eyes from closing. Our thought processes feel empty and shallow. We generally feel a growing pressure to think of something meaningful and worthwhile to say, yet nothing of value occurs to us. There are times that our emotional reactions in response to the patient's suffering are not what we think they should be. They may be contrary to the point of seeming perverse. Instead of being moved to sympathy or compassion, we may feel a cold indifference, disgust, contempt; we may even have the unsettling experience of wishing even worse things on the patient.

If the patient is sitting up and looking at us rather than lying down, we may often feel ourselves in danger of being caught dozing off or otherwise being distracted. Such lapses may cause us to feel anxious and guilty. We may find ourselves furtively glancing at our timepieces in order to find out how much longer we shall have to put up with the torture.

Should a patient be more aware of his anger and hate, both his assaults on our feelings of goodness and competence and his rejection of the limits of the setting are likely to be more overt and direct. Our reactions are likely to be clearer and more focused. And if we fully own all of the feelings that are induced in us by the patient's denigration and contempt and by his inappropriate demands and his intrusive behavior, we may find ourselves, at times, feeling an intense hatred either for the patient, ourselves, or for both. At times we may feel like urgently getting rid of the patient, or we may feel like leaving the field of psychoanalysis.

Until such time as the therapy successfully dissolves his defense-resistances to enable a given patient to emerge from his borderline ego state, the therapist can expect to experience himself as having nothing of value to offer. He will have to endure what can be fairly summed up as a bad-therapist feeling. This feeling when not understood and accepted as the inevitable emotional accompaniment to the work, occasions feelings of shame and guilt and fraudulence for taking fees from patients to whom we are apparently being so unhelpful, and when under the sway of this feeling, we may feel reluctant to consult our colleagues concerning the problems we are having with such treatment situations.

Now I would like to offer my best understanding of the meaning of this negative transference/countertransference matrix.

It is, I believe, a consequence of the impact of the psychoanalytic situation on the borderline personality organization. All of the patient's resistant behaviors and our induced countertransference disturbances can be understood to be a reflection of the patient's best efforts to cope with and survive the annihilation anxieties that are evoked in the therapeutic interaction; and the severity of such transference/countertransference disturbances may be diminished or exacerbated depending on the analyst's management of what Sullivan called the patient's gradient of anxiety.

This transference/countertransference matrix signifies that we are involved with a person whose self/other boundaries are ill-defined and permeable, and whose ego has failed to develop

the strength to bear disturbing and conflictual mental contents in consciousness long enough to submit them to processes of thought or to what Bion has called reverie.

When a person with such an unstable and permeable personality organization enters a relationship with an emotionally significant other person who is more intact, stable and comfortable with himself, the impact is likely to be both intensely exciting and potentially disorganizing.

Because of his actual dependency on the analyst for therapeutic help, and because of his fantasies of the analyst's superior mental health and superior competence to live a satisfying life—fantasies which are both reality based and projected—the analytic situation is likely to be experienced as especially agitating and stressful. The patient's ego is immediately assailed by an upsurge of unbearably painful and violent mental contents.

Were he to be undefended vis-à-vis the perceived or fantasied superior goodness and competence of the therapist, the borderline patient would experience an intensification of feelings of badness, agonizing feelings of deficiency, excruciating envy, and a murderous hatred of either, or both, himself and the other.

Were the patient to be undefended, he would become aware of a terrifying helplessness to cope with his vulnerability to the intense abandonment anxieties that would be evoked by the very fact of the therapist's separate existence, of his power simply to be himself. The patient's defense resistances enable him to remain unaware of his actual dependency on the therapist's capability to do good-enough therapy. His dependent, clinging, intrusive and demanding behaviors are rarely accompanied by an experience of the terror of loss and abandonment. Such manipulative behaviors are powered by compensatory omnipotent strivings and grandiose fantasy, the aim of which is to negate any experience of the separateness and otherness of the analyst, and of the analyst as the object of his attachment needs. The experience of vulnerability to being failed by the analyst—as he was by his parents—is obliterated by the paradoxical belief that the nullified other can be emotionally dominated, controlled

and coerced so as to yield favors and care-giving of one kind or another.

Our negative countertransference experiences can best be understood as the inevitable consequence and counterpart of the patient's primitive interactional defenses, namely externalization, splitting and projective identification, and what Bion has called primitive communication.

The aim of such projective processes is twofold: to urgently rid the psyche of the painful affects and unwanted self and object parts that would give rise to unbearable and potentially disorganizing experience, and to aggressively penetrate the analyst's insides and deposit there the evacuated, toxic mental contents. The purpose of this transfer of mental contents is to achieve an emotional domination and control of the analyst as the object of denied attachment needs, and to achieve, as well, within the unequal therapeutic dyad, a more equitable distribution and balance of goodness-and-badness and power-and-weakness.

Spotnitz says that in this way the patient attempts to make the analyst into a defective person, more like himself, and, therefore, a person more comfortable to be with. Spotnitz has termed this the patient's need for a negative narcissistic transference. I prefer negative *self-object* transference—a modification of Kohut's "self-object transference."

I should say something about the patient's use of primitive communication. Bion's theory of primitive communication is one of his most brilliant and useful contributions. It accounts for our otherwise unaccountable cognitive disturbances of concentration, attention, and sleepiness. According to Bion's theory, speech and language processes become primitivized so that they lose their primary function which is to communicate symbolic understanding. They become the instruments for the urgent evacuation and the transfer of unconcious accretions of psychic disturbances, and for the creation of impervious barriers to the communication of meaning, for the actual destruction of meaning.

Truth and understanding and meaning are dreaded because they would make the borderline patient conscious

of unbearable experience. Thinking gives rise to meaning, and therefore, the borderline patient by means of primitive communication, attacks and successfully scrambles our thinking processes. At such times, when the patient is bombarding our minds with unconscious elements of psychic disturbances—which Bion termed Beta elements—the best we might be able to do to survive the situation is to fall back on the security operation that Sullivan called "somnolent detachment"—a psychobiological defense that we develop in early infancy to cope with the anxieties evoked by our mother's empathic failures.

As a simple matter of fact there is truly nothing that we can do to prevent ourselves from experiencing such cognitive disturbances unless we intervene in a way that interferes with the patient's primitive communication. This may, or may not, be a good thing to do.

For all of the foregoing reasons, until the patient has emerged from his primitive mental state, we cannot expect to enjoy the feeling of being a good analyst. The patient, because of his dread of meaning, because of his split-off destructive envy, and because he is haunted by feelings of badness—which are heightened and perpetuated by his nullifying destructive interactions—simply cannot allow us to enjoy feelings of goodness. The better he allows us to feel about ourself, the worse he would have to feel about himself. We have all had the experience of having friendly normal sessions with such patients only to have them turn the next session into a shambles, vitiating all feelings of mutuality and shared goodness.

In working with such patients we are in a paradoxical situation. We must learn how to function competently while feeling incompetent.

Our feelings of incompetence do not necessarily signify that the therapy is not progressing. The patient may not be able to afford to recognize progress because this would require him to acknowledge that the therapist might have had something to do with it. He might then be vulnerable to unbearable envy and to the terror of loss and abandonment.

The point is that neither the therapist's nor the patient's negative feelings should be taken at face value as valid indicators that the treatment is inadequate. Confidence in the treatment should be based on more objective criteria such as signs of improved functioning. For example:

> The patient functions better at work and in his outside interpersonal relationships.
>
> His symptoms diminish: somatic complaints, sleep disturbances are reported with decreasing frequency.
>
> Addictive behaviors diminish, such as alcohol and drug abuse and overeating. The patient gives up smoking.
>
> Complaints of outside suffering diminish in favor of complaints more focused on the therapy and the therapist.

We shall gradually be permitted to feel competent as the therapeutic process strengthens the patient's ego sufficiently to enable him to bear unbearable experience—especially the upsurge of bad feeling which is stimulated in relation to the analyst—and as it enables him to formulate this experience on the level of language and to discharge it in meaningful speech, thereby rendering obsolescent his evacuative and projective defense-resistances.

I should like to present what I have found to be a therapeutically useful perspective on the relationship between borderline psychopathology and countertransference.

When Winnicott wrote of failures of adaptation, he was referring to an environmental failure to adapt to the maturational needs of the developing child. In keeping with this view I have differentiated two ways in which the human environment has typically failed those patients who present primitive mental states. I have termed these, respectively, the primary environmental failure of adaptation and the secondary environmental failure of adaptation. The primary environmental failure refers to those chronic and repetitive parental failures to meet the particular constellation of maturational needs which is presented by the patient in infancy and early childhood.

Winnicott makes the point that when "for the immature child" the mother "becomes the target for excited experience

backed by crude instinct tension," she "has to be found to survive instinct-driven episodes which have now acquired the full force of fantasies of oral sadism and other results of fusion" and that "to survive in this context means not to retaliate" (Winnicott, 1968).

I would translate this to mean that when the child induces bad feelings and/or feelings of badness in his care-givers, he needs them to contain and process these feelings in such a way as to enable them to respond without making the child a bad or nogood person in return, and without subjecting the child to the terror of being physically and/or emotionally destroyed or abandoned.

I would speculate that the borderline patient, as a child, was failed in this regard and that his ego's best efforts to cope with this primary parental failure resulted in the internalization of a strife-torn self-and-object-world that, for reasons that I have outlined above, he must thereafter externalize and project at some point in the course of all subsequent emotionally significant relationships.

Other persons in his life who become the target of such projective processes are typically impelled to react defensively and counterprojectively. Another way of putting this is that in ordinary interpersonal transactions, such transference projections typically evoke responses which are strongly under the sway of raw, unprocessed countertransference reactions. The borderline patient's psychopathology begets the very kind of response in others which reinforces and perpetuates it. This failure of the human environment to respond in ways that might correct the intrapsychic warping that was laid down in response to the primary parental failure of adaptation I would term the secondary environmental failure of adaptation.

From this perspective, it can be seen that the negative countertransference experience generated by patients presenting primitive mental states becomes our main instrument of therapeutic leverage. If we can own this experience and inhibit our urges for riddance, retaliation, and counterprojection, if we can address this experience for its informational value, and if we can succeed in determining what the patient needs us to do with our negative feelings, we shall, in effect, be performing,

over what Sullivan called the "long haul of therapy," a maturationally corrective, facilitating task which no previous caregiver in the patient's lifetime has either had the knowledge or the will or the capability to perform.

All of the internal work that the analyst does with his countertransference—inhibiting retaliatory impulses, holding the patient's evacuated mental contents in consciousness long enough to submit them to processes of reverie which cleanse them of their toxicity—is akin to the internal work that the good-enough mother does in both surviving and maintaining her connection to her baby during those episodes in which she "becomes the target for excited experience backed by crude instinct tension."

Gradually the patient comes to internalize the analyst's capability for impulse control and for containing and processing conflictual and dysphoric mental contents.

In conclusion, I want to address briefly what I believe to be an unconsciously based impediment to our living and working with the bad-analyst feeling.

Any person who is made to feel bad or not-good-enough for the other person is likely to experience a threat to his self-esteem. For psychoanalysts, the bad-analyst feeling presents a similar problem with, however, an additional feature, namely, that for most, if not all of us, the bad-analyst feeling frustrates a core unconscious need that may have brought us into the field and which persists in requiring satisfaction. I am referring to our need to make reparation to our internal parental objects.

To the extent that we failed to be good-enough sons and daughters to cure our real parents of their mental pain and anguish so that they could have been more loving to us, we remain haunted by a sense of badness which we need to expiate by proving ourselves to be good-enough analysts to cure our patients.

As Racker has pointed out, the patient can be as much the object of the analyst's countertransference neurosis as is the analyst the object of the patient's transference neurosis.

The bad-analyst feeling may revive the unconscious despair of our child-self that it can ever be good enough for our parents.

In this emotional situation our frustrated child-self eclipses our adult analytic-self. From this position we may be unable, and in all likelihood, unconsciously unwilling to do the hard work of functioning as a good analyst while feeling like a bad one, until we contact the full force of the hatred we feel for the patient as the bad parental object who is once again depriving us of our need to make reparation.

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Joining, mirroring, psychological reflection: Terminology, definitions, theoretical considerations

Benjamin D. Margolis

Introduction by Marcus M. Silverman

I was assigned very early in my training Margolis's *Joining, Mirroring, Psychological Reflection: Terminology, Definitions, Theoretical Considerations* (1986). It is a paper I revisit often. I originally experienced it as a useful primer on psychoanalytic technique—his breakdown of joining (p. 24) says in one single-spaced page what years of analytic training attempts to illuminate—in a form and style accessible and easy to comprehend for novices. But over time it has grown with me, or I with it, and crystallized into an meaningful keystone of what holding an analytic position might be—and something far harder to verbalize about the profound absurdity of psychoanalysis itself.

An aside—something I think about: is psychoanalysis funny? Certainly *New Yorker* cartoons would suggest that someone, somewhere, finds it funny. At the very beginning of training, when I would first encountered Margolis, I was routinely (and predictably) scandalized by some of the anecdotes and mythologies of CMPS. Maybe you know some of them, too—Hyman Spotnitz

threatening to bash someone's head in with an ash tray. On page 24 of this piece, Margolis models an exchange:

> P: I didn't feel like coming here and seeing you today.
>
> A: I can't say I was looking forward with great eagerness to seeing you today.
>
> P: What's the use of my saying this over and over again?
>
> A: What's the use of my listening to this over and over again?

I think something that wasn't at all articulated in me at the time and that I still struggle to understand to my satisfaction is to what extent there is a deep, unconscious, simmering comedy-of-absurdity that underscores the practice of psychoanalysis, broadly, and exchanges like this, specifically. A modern analysis is particularly conducive to this sort of exchange because of its great intimacy with aggression—which certainly can be comic. What I didn't understand then, and what I imagine now, is that *Hyman Spotnitz threatening to brain someone with an ashtray is comedy*. And that the patient himself is understanding, perhaps unconsciously, the absurd comedy of your therapist threatening to attack you. It is obviously other things, too—scary, titrating, mirroring, dystonic. But it is, in fact, absurdly humorous. Or how else is one to understand Margolis's comment here in "Special Situations" beginning on page 27:

> P: Then why do you still go on [living your life] anyway?
>
> A: What should I do? I'm like a wound-up clock. Destiny has wound me up and I'm just ticking away.

I suspect that part of the difficulty of truly understanding what makes for a compelling analytic position is, as Freud discusses broadly in *Wit and Its Relation to the Unconscious,* that it is impossible to explain a joke/why something is funny in language, in the same way that it's impossible to explain a dream, because it is ultimately a discussion of unconscious material. And more so, that there is an important distinction between jokes and comedy. Jokes are a language game, where the most essential purpose is amusement. Absurdity, or humor, or Freud's "wit" are a broader, phenomenological concept and, per Freud, they touch our unconscious and arouse something preverbal in us, akin to what dreams are linked to. This arousal, I believe, parallels part of what makes the psychoanalytic position—how the analyst holds, creates and contains the environment of the analysis. Like a joke—with its setups, misdirection and punchlines—Margolis's piece masquerades as some kind of primer (". . . terminology, definitions . . . ") but is also filled with this more unconscious and

deeply witty subtext, particularly his work as he describes it with patients. Margolis writes,

> We may elaborate Spotnitz's views as follows. The patient has entered treatment with reluctance, suspicious of the analyst, in whom he is prepared to find a personification of societal demands and pressures and ultimately of the omnipotent and frustrating mother figure of early life. Instead, he finds a mirror image of himself, a therapist who supports his negative attitudes and encourages him to maintain and even elaborate his resistance patterns. The patient reacts hesitantly, testing the analyst›s good faith with ploys and maneuvers. In the course of developing the narcissistic transference, he gradually comes to accept the analyst as his true double, a figure whose ego matches his own (p. 32).

I suppose my point is largely that this praxis in and of itself is a deeply absurd performance. It is steeped in absurdity, which in turn makes it comedy. I am a middle-aged man with some education. I make my living and profit from a performance (the analytic position), in which I take on, reflect back, join and mirror another's self-defeating, negative, hateful, and resistant ideas about himself, and he pays me for my time. Though I know nothing about what Benjamin Margolis was like as a person, friend, colleague (his death preceded by some years my arrival at the Center for Modern Psychoanalytic Studies); and I don't know to what extent he would have been conscious of, or interested in, absurdity within the paper under discussion here, I can't imagine he wouldn't be receptive to it as part of the unconscious lifeblood of psychoanalytic work. I suppose I ask that, when you read Margolis's paper this particular time, you pay close attention to how he is as the writer of the paper (academic, scholarly, serious) juxtaposed with the version of himself he paints as the analyst (A: . . .):

> A: You can get killed in your bathtub.
>
> P: Or in your bathtub, right.
>
> A: Or open a polluted can and get, what do you call that stuff that you get?
>
> P: Botulism?
>
> A: Botulism, yes.

Joining, mirroring, psychological reflection: Terminology, definitions, theoretical considerations*

Joining is a powerful technique for resolving narcissistic resistance in psychoanalytic therapy. Its very power, however, calls for prudence in determining when and how to apply it. In the hands of the uninitiated, and used without reference to the larger maturational purpose which it aims to advance, joining, especially in its dystonic form, may subserve analytic aggrandizement against the patient; at worst, it may destroy the analysis. In this spirit, Spotnitz (1976) warns against using the joining technique as "a gimmick, a device that can be flicked on mechanically" (p. 42), and Nelson and Nelson (1957) similarly advise against "shotgun" application (p. 12).

The nucleus of therapy with the preoedipal patient is in the transference-countertransference relationship, reflected in the patient's evolving feelings toward the analyst and the latter's perception of the process through the medium of his own induced feelings. Generally speaking, technical skills such as joining come into perspective only as they further the objectives of a comprehensive therapeutic design associated with the patient-analyst relationship. The joining technique, powerful as it is, has no intrinsic significance. It is means to an end. Its value derives wholly from its role as handmaiden of a clinical method. If, therefore, we elect to study its many uses in treatment and to trace the sources of its effectiveness, we do so only in order to clarify how modern analysis goes about its pursuit of larger analytic goals.

Terminology

Modern psychoanalysis has often been called the joining method. This is surely a limited view of what happens in the

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* This paper evolved out of a series of summer workshops in modern psychoanalysis given by the author at the California Graduate Institute. Originally published in volume 11(1–2) of *Modern Psychoanalysis*.

treatment of the preoedipal patient. Joining is after all merely one treatment technique. It takes its place among other modalities, such as mirroring, object-oriented and ego-oriented questions, confrontation, commands, explanations and finally interpretations. It is true, nevertheless, that joining is one of the most powerful instruments devised for dealing with resistance in the therapy of narcissism.

It will repay us first to clarify the terminology that has developed over the years around the joining concept. Confronted with the stonewall resistance of the narcissistic patient in treatment, Spotnitz and his co-workers early on hit upon the notion of proceeding in accordance with the old adage, "If you can't lick 'em, join 'em." We shall soon see how they went about putting this strategy into effect. The new procedures, in any event, demanded a supplementary vocabulary. The papers describing the modern approach and its results that subsequently appeared in the professional journals, sprouted a new idiom. Joining, mirroring, psychological reflection, siding with the resistance, supporting, reinforcing—these and other expressions made their appearance in order to convey what was taking place in the therapists' offices. The so-called "paradigmatic" approach (Nelson, Nelson, Sherman and Strean, 1968), a parallel clinical method which took its cue from a similar view of the narcissistic patient and his resistances, added to the above its own quota of terms, such as, active mirroring and role playing. The terms employed most frequently in both approaches were joining, mirroring and psychological reflection.

A certain confusion has by now developed over the exact meaning of these terms and how they differ. The literature of modern psychoanalysis, in its mushrooming growth, offers ambiguous aid in clarifying these concepts. Thus, psychological reflection and mirroring are synonymous (Marshall, 1982, p. 14; Spotnitz, 1976, p. 37; Spotnitz and Nagelberg, 1960, p. 195); psychological reflection and joining are synonymous (Clevans, 1976, p. 144; Meadow, 1974, p. 81; Spotnitz, 1976, p. 37; 1985, p. 183; Spotnitz and Meadow, 1976, p. 181); joining and mirroring are synonymous (Davis, 1965-66, pp. 93, 100-101; Nelson, 1962, p. 121); joining is a form of psychological reflection (Kirman, 1977, p.

172; Spotnitz, 1976, p. 37); joining is accomplished by means of mirroring (Strean, 1964, p. 35); joining is accomplished by means of psychological reflection (Spotnitz, 1976, p. 27); psychological reflection is accomplished by means of joining (Spotnitz, 1976, p. 134). Some attempt at differentiation would appear to be in order. A careful reading of texts yields the following tentative conclusions regarding the interrelationships of these terms.

As the concepts have developed and are now most frequently used, it is reasonable to say that mirroring and psychological reflection are one and the same. Joining and mirroring (psychological reflection) represent two forms of modern analytic technique for dealing with preoedipal resistance. Each in its way affirms a similarity between the egos of analyst and patient, and they may therefore be viewed as variant applications of the same approach. Having pursued these distinctions this far, we must now acknowledge that "joining" and "psychological reflection" have each by common usage come separately to serve as umbrella terms for the combined joining and mirroring techniques. This is for purposes of general reference. Caution is indicated, however, when discussing specific treatment procedures, to distinguish between joining and mirroring (psychological reflection) *qua* techniques.

The writings of Hyman Spotnitz, originator of these procedures, provide the most authoritative formulations of the techniques and offer striking examples of their use in psychoanalytic therapy. (See especially Spotnitz, 1976, 1985.)

Definitions

In simplest terms, joining and mirroring refer to a communication from the analyst which conveys to the patient that the analyst agrees with him. Several levels of agreement are involved, matching the patient's conscious feeling state behind it.* If the analyst is in resonance with the patient, his joining and mirroring

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* For a discussion of conscious and unconscious resistance patterns and motives, see Margolis (1984).

remarks, while addressed to the literal resistance message, will simultaneously engage the unconscious emotional contents sheltering behind it. These concealed contents constitute the patient's true affective disposition, which is usually at variance with the onedisplayed in the manifest resistance. And just as the patient's overt resistance communication is linked to subterranean emotional tendencies, so does the analyst gain access to these tendencies by allying himself with the overt resistance pattern. In other words, in joining the manifest resistance, the analyst is also speaking to the unconscious forces warded off behind it. He thus informs the patient that it is acceptable to entertain both his resistance attitudes and the unneutralized aggressive and libidinal feelings which they defend against.

In the case of joining, agreement may take a variety of forms. The analyst may simply say "Yes" or "That's right," he may echo the patient's statement by repeating it in the same or different form, he may accept the patient's views and encourage him to maintain them, he may "pursue the patient's perception" (Spotnitz and Meadow, 1976, p. 204) by helping the patient elaborate on it. These procedures, each in its way, indicate the analyst's agreement with the patient. They constitute different means of "going along with the resistance" (Spotnitz, 1976, p. 178), "siding with the resistance" (Sherman, 1961-62, p. 44; Strean, 1964, p. 35), "supporting and reinforcing it" (Spotnitz and Nagelberg, 1960, p. 193; Davis, 1965-66, p. 84), in short, *joining* it.

The agreement may be with a specific comment of the patient about himself or others.*

P: I slept poorly last night and feel tired today.

A: You look tired.

P: I feel miserable.

A: You're entitled to feel miserable.

Or the analyst may join the patient's total set of values or attitude toward life.

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* These illustrations, as well as most of those that follow, are limited, for brevity's sake, to two-line exchanges. This by no means typifies the joining technique, which often generates extended dialogues between analyst and patient, and may also take non-verbal forms.

P: (after a harrowing review of his life history) I haven't had much in the way of pleasure.

A: Life has been one misery after another.

In the case of mirroring (psychological reflection), agreement takes the form of communications in which the analyst presents his own condition or attitude as matching that of the patient. Thus, the analyst may respond in kind to a statement by the patient. For example, if the patient devalues the self (himself), the analyst devalues the object (himself). If the patient directs a question to the analyst, the latter directs a similar question to the patient. If the patient expresses certain thoughts about the analyst, the latter expresses similar thoughts about the patient.

P: I want to think about it before deciding to enter treatment with you.

A: And I want to think about it before taking you on as a patient.

P: I'm thinking of stopping analysis.

A: I'm considering discharging you.

In a more elaborate scenario, the mirroring is not of a single thought or attitude of the patient, but of his total approach. For example, a self-centered patient spends session after session complaining about his aches and pains or his distressing feelings or experiences, without making contact with the analyst. The latter then begins to ask questions about himself, directing the patient's attention to the analyst. "Is there something you want of me in connection with these feelings (experiences)?" Or, "How do I feel about the things you're describing?" The analyst is doing exactly what the patient is doing, reflecting the patient's self-centered attitude. Depending on the maturational context, the analyst may also mirror the patient's silence with silence of his own, respond in an aloof manner to the patient's intellectualizations, or counter the patient's vacillation with a parallel indecisiveness.

Joining and mirroring may be ego-syntonic, i.e., fall pleasurably upon the patient's ears, or ego-dystonic, i.e., abrasive and unpleasant. It is difficult to convey on the printed page the special quality that renders an intervention syntonic or dystonic. The verbal content is, of course, important. Crucial, however,

is the emotional charge attached to the verbal content. This is what defines its pleasant or unpleasant character and in either case exercises a maturational effect upon the patient. A harsh or friendly tone of voice, adding a hint of asperity or a touch of gentleness, will confirm or modify the sense of the spoken word. Emotional communication in the form of joining and mirroring interventions is thus capable of registering endless nuances of interplay between content and feeling, and of providing the patient with emotional experiences of infinite syntonic and dystonic variety (Margolis, 1978; Sherman, 1983). Very little of this interplay, particularly from the emotional side, is amenable to reproduction in print. In the examples that follow, the reader may supply, if he desires, imagined emotional resonances to go with the interventions and heighten or temper their effect.

Ego-syntonic joining:

P: I had to plow through a lot of snow to get here.

A: You showed a lot of determination.

P: My mother was more interested in having fun than in taking care of me.

A: She neglected you.

Ego-dystonic joining:

P: I feel worthless.

A: You *are* worthless.

P: I feel hopeless.

A: There's no hope for you.

Ego-syntonic mirroring:

P: I feel depressed.

A: So do I.

P: I'm not doing so well in the analysis.

A: Perhaps I'm the one who's not doing so well.

Ego-dystonic mirroring:

P: I didn't feel like coming here and seeing you today.

A: I can't say I was looking forward with great eagerness to seeing you today.

P: What's the use of my saying this over and over again?

A: What's the use of my listening to this over and over again?

In general, ego-syntonic joining is employed when the patient's ego is judged to be in a fragile state and he stands in need of careful reinforcement of his current defensive patterns. This is often the case at the beginning of treatment. Ego-dystonic joining, while also supportive of the patient's resistance patterns, is employed when the patient is judged to be capable of withstanding his own impulsivity and of confining himself to verbal expression of feelings.

Joining as related to stages of resistance

The techniques of joining and mirroring are employed for one purpose only, to resolve the narcissistic patient's resistance to putting his thoughts and feelings into words. The resistances vary with the individual, but they tend to fall into certain general categories. These have been discussed by Spotnitz (1985, pp. 175-183) under the headings: treatment destructive resistance, status quo resistance, resistance to analytic progress, resistance to cooperation, and resistance to termination. The categories represent stages in the upward maturational mobility of the patient in a successful analysis. In terms of treatment goals, the categories stand for the steps in the patient's progressive emotional evolution from isolationist self-absorption through narcissistic transference to object transference, in other words, from early preoedipal, to later preoedipal, to oedipal.

Keeping in mind that joining is employed primarily in order to resolve the resistances of the preoedipal patient, the technique is introduced with the utmost caution in the early phases of treatment, when the patient's ego is most fragile. Its use increases in frequency and in intensity of impact as the narcissistic transference develops and the patient forges new ties to reality in the person of the analyst. Joining interventions then begin to decline in number, as the patient gradually withdraws from the complete symbiotic stage attained in the narcissistic transference and begins to achieve the self-other separateness manifested in object transference (Margolis, 1979, 1981). Thus, joining procedures are used sparingly in dealing with treatment

destructive resistance, which tends to occur at the beginning of treatment. They appear with mounting frequency and intensity as status quo resistance is activated. They achieve maximum use in dealing with resistance to analytic progress. They fade into intermittent application and stand-by status when confronted with resistance to cooperation. And their use is revived again on a temporary basis, often in a harshly dystonic form, with the appearance of resistance to termination.

The rich variability of individual development produces endless permutations and combinations among the elements of the foregoing sequence. Some constants stand out, however, and they invite structuring of the process. Short of reproducing the verbatim protocols of a chain of sessions, it is impossible adequately to convey the complexities of analyst-patient interchanges that sustain the treatment process. The following examples of joining and mirroring interventions must therefore be viewed as mere “trail markers” that identify the stages of resistance and provide some notion of the use of joining communications in the resolution of different resistance types.

Treatment Destructive Resistance. As the name implies, this form of resistance, usually in the early phases of treatment, imperils the analysis. It must be dealt with at once, preferably by questioning and investigating the patient’s attitudes, occasionally by joining.

P: I feel as though I’m falling apart.

A: Am I falling apart too?

P: I’m thinking of stopping treatment.

A: Why am I doing such a poor job that you want to get away from me?

In both cases, the analyst is trying by means of mirroring to draw the patient’s attention to himself. This leads the patient to stop scrutinizing his own shortcomings and impulses and to focus on the object (analyst) and his possible defects. The aim is to involve the patient’s feelings with the analyst and lessen the danger of disruption of therapy.

Status Quo Resistance. The patient, having resolved his initial resistances and made visible progress in the analysis, has now arrived at a stage where he is quite satisfied with himself and

with his relationship with the analyst, and prefers to stay exactly where he is. In the transference, he attributes this attitude to the analyst.

P: You don't mind my silences. You just like my company.

A: What's my problem that I like you to be silent?

The analyst, joining the patient's view of him, proceeds to investigate why he, the analyst, is that way.

Resistance to Analytic Progress. Having resolved his status quo resistance, the patient is now confronted with the prospect of advancing into unknown territory where hitherto successfully repressed memories, thoughts and feelings lurk. He resists venturing forth, and the analyst deals with this resistance when the patient expresses it as a transference feeling.

P: I think you'd rather I relaxed and didn't bring up any troublesome new problems and ideas.

A: Why would I have an attitude like that?

Again the analyst joins the patient's view of him and pursues it.

Resistance to Cooperation. The patient has by now resolved his resistance to communication, has gradually begun to establish object transference, and is able to speak more freely of his thoughts and feelings. He does, however, balk from time to time and, in revival of his former narcissistic attitudes, hesitates to continue progressive productions and dialogue. Joining is now one of several options, since the patient's ego has become strong enough to accept explanations and interpretations as well.

Resistance to Termination. The patient will often greet the prospect of termination with a revival of his old problems and with complaints that nothing has changed. He will also report that new problems have appeared. He seems to be saying: I don't want to be adult and independent. His renewed narcissistic resistances are once again joined and mirrored—often sharply dystonically in order to test his resilience—until he arrives at a full acceptance of his new role as an adult.

Special situations

There are many special situations in the therapy of the narcissistic patient that call for joining procedures. Each pathological syndrome rooted in the preoedipal period requires particular joining techniques that will help resolve the resistances specific to it. Perhaps the special situation that arises most frequently, along the entire spectrum of preoedipal disorders, is represented in the resistance to voicing aggressive feelings. This is so because at the root of all narcissistic disorders is found the narcissistic defense, a repudiation primarily (though not exclusively) of the aggressive impulse. The therapist working with the preoedipal patient in whatever context is destined to deal with the varied consequences of the narcissistic defense. The patient avoids experiencing and expressing negative feelings with a doggedness born of a fear of annihilation. Depending upon his character structure and the etiology of his disorder, he will resort to paranoid attitudes, depressive or delusional states, silences, self-disparagement, psychosomatic equivalents of his affective processes and other forms of self-attack. When these manifestations begin to infiltrate the transference relationship, joining becomes a necessary strategy for engaging the resistances they present. The ultimate purpose, in every instance, is to help the patient mobilize and liberate the negative (as well as the positive) feelings he has long kept submerged. The analyst accomplishes this by first joining the patient's resistance and supporting and reinforcing his uncooperative attitudes. He helps the patient maintain the narcissistic defense until the latter feels secure enough to give it up of his own volition.

The following excerpt provides an example of the uses of joining and psychological reflection in the treatment of depression in one particular context. The patient was a young woman who had entered treatment because depressive episodes interfered with her functioning.

> P: If you really look at things the way things are, I am unimportant. It's the truth. Everybody is unimportant. It's just that some people like to believe that they're important.
>
> A: Does that include me?

P: Yes. It includes everybody. I mean, what good are you, or me? What good is anybody if they have to die? What's the sense at all of being born? Let's say, what good are you?

A: Yes. What good am I?

P: I don't know. I don't see that there's any good in anything or anybody at all.

A: I certainly can't keep you from dying, or even myself.

P: Right. That's just what I was thinking. I don't understand why anybody is doing anything they're doing in the world. The people who might be considered the psychiatric people in a way are living the best lives. Because they're into spells. Criminals also. There's absolutely no reason not to steal, cheat, lie, murder, anything. It doesn't matter. People are doing all these stupid things like making money, having jobs, going to school, working. There's just no point at all in these things of civilization. We should live like animals. It should be survival of the fittest, where we just kill off whoever gets in our way. There's no point in trying to live eighty years. There's absolutely no point to my life. I don't understand what I'm doing. And that's the part that makes me feel sick… hearing those crazy people out there telling me there is a point to my life. There's no point to my life. What do you have to say? Say something.

A: It's very impressive.

P: What's very impressive about that?

A: Your whole point of view, yes.

P: You're just saying that so I'll talk more, probably. What do you find impressive about it?

A: There's a great deal of truth in it.

P: Then why do you still go on doing things anyway?

A: What should I do? I'm like a wound up clock. Destiny has wound me up and I'm just ticking away.

P: Oh, I hope that's not true. Is that really true?

A: What else is there? You go through your daily rounds, over and over again. Then along will come a day when somebody will press the wrong button and that will be the end of us all.

P: Who's that?

A: I don't know. Some crazy man either here or in Russia or someplace will just press the wrong button and that will take care of all

of us. Or maybe there'll be a slow death, maybe the atmosphere will give out, there'll be pollution and everybody will die of something or other. The planet will become uninhabitable. How many people can escape to the moon?

P: Why do you want to live, if you expect that? What difference does it make if you die today or five years or ten years from now?

A: Not much difference.

P: And wouldn't it be so much more satisfying if you could kill yourself, like if you knew that's only the real worthwhile thing doing in life because you have control over it then. It's much more satisfying than if you left it to nature or whatever you want to call it, if you had a physical illness or a heart attack or something like that or if you left it to chance and you had an accident and can be run over by a car or were in a train wreck.

A: You can get killed in your bathtub.

P: Or in your bathtub, right.

A: Or open a polluted can and get, what do you call that stuff that you get?

P: Botulism?

A: Botulism, yes.

P: Right. Or one of the things that you said before, like somebody will push the wrong button or it might be a slow death. Isn't it really the only satisfying thing to be able to kill yourself and say, okay, today's the day, this is what I'm going to do with my life and let them put something like that on my tombstone, and let all the dumb people who are still living come and stand there and cry for me. But I really did it. I killed myself. I did the one worthwhile thing in life—was to kill myself.

A: Well, it's something to think about, as long as you keep coming here and telling me what you're thinking.

P: Absolutely. It really is something to think about. And it makes me feel better in a way talking to you about it. It makes me feel that I'm in control of my life after all—and I don't have to kill myself to prove it. (After a pause, the patient launched cheerfully into another matter.)

Note the circumspection with which the joining and mirroring are employed. The patient is fragile, and the analyst is intent upon creating a secure setting in which the patient can feel free to express her feelings to their fullest. The joining interven-

tions are therefore all syntonic. They help the patient voice her suicidal thoughts and they open the way to expression of the sweeping homicidal attitudes that lie behind them. The narcissistic defense finally gives way to a sense of control over her life which is associated with the experience of telling all to the analyst, and which can now be expressed through living rather than through dying. How the joining procedures have wrought this change in the patient's frame of mind is of no small interest. We may now proceed with a discussion of the theory of joining.

The theory of joining

Observing the effectiveness of the joining technique in resolving the different forms of narcissistic resistance, the reader may have wondered how this was accounted for in theory. Why is joining effective? What characteristics of the narcissistic patient not merely exclude rational interpretive measures but actually dictate procedures such as joining and mirroring?

As we know, the preoedipal patient interrupted his own emotional growth and established the narcissistic defense at a very early stage of development out of anxiety over his unacceptable impulsivity, aggressive and libidinal. It stands to reason that he will present many obstacles to a therapist bent upon helping him achieve awareness and release of feeling. For all their diversity and ingenuity, however, his multiple resistances are nothing but derivatives of the overriding negativistic defense pattern so typical of the narcissistic patient. "Such negativism," Nelson (1967) declares, "[is] representative of a preverbal insulation barrier activated to protect the organism against overstimulation" (p. 9). But what was once normal negation has been transformed, under the impact of unwholesome interactions with the mother, into a posture of "malignant No," in Lichtenstein's (1977) phrase. The preoedipal patient, fixated at the narcissistic phase, says No to the world. He defends his fragile emotional economy by turning a deaf ear not only to the stimuli that press upon him from without, but also to his own psychic processes. In these circumstances, any attempts to address his problems with rational interpretations and insights meet

a stone wall, at best of incomprehension, at worst of negation. The narcissistic patient's No connotes more than denial; it is an action equivalent, an assertion of antithesis. That is what is meant when we say that the narcissistic patient is negatively suggestible. In the service of the narcissistic defense, he will assume an attitude, take a position, perform an act, in exact contravention of the conventional or suggested one.

How to deal with such unyielding resistance pattern? From much work with schizophrenic and other narcissistic patients, Spotnitz (1976, 1985) gradually evolved the notion that the way to exert an influence for change on these patients was for the therapist to ally himself with the patient's position against change. This required that the therapist align himself in favor of the resistance. He was to forgo all efforts at inducing the patient to give up his defensive pattern. Instead, he would support and reinforce it and help the patient maintain it. He named this procedure the "joining" method, and devised numerous variations to meet the many forms of narcissistic resistance.

The effectiveness of the joining method in reversing narcissistic pathology has generated widespread clinical and theoretical comment. We are indebted to Robert Marshall (1982) for his thoroughgoing review of the background literature bearing on the subject, notably with regard to mirroring. According to Davis (1965-1966), four different theories have been advanced to explain the dynamics of the joining approach. (1) Sherman (1961-1962) proposes that the phenomenon of ambivalence underlies the process. The patient is in an unsettled mental state and is open to fluid changes from one attitude to another. When the analyst overtly adopts the patient's position, the latter, out of his customary negativism, switches to an antagonistic one. This switch moves the patient to a position opposed to his previous negative one; he finds himself taking a positive view. (2) Nelson (1956) bases her explanation on the assumption that, during the preoedipal period, the patient reacted to a frustrating object (mother) by internalizing a representation of the object. The internalized frustrating object, the toxic introject, is now an integral part of the ego and resists efforts at effecting maturation in the analysis. Nelson suggests that the analyst, in joining the patient, takes on the role of the introject, which the

patient can now reexperience as an external object. This enables him to express externally the forbidden feelings that have been tormenting him internally, and thus to separate himself out from the unhealthy introject. (3) Davis himself hypothesizes that the joining intervention evokes a surprise reaction in the patient. This releases other feelings, including anger. "With respect to the discharge of the latter affects, it is as though a powerful ally has intervened in the life of the patient, taking over some of the more onerous tasks (his defenses), thus freeing him to experiment with new attitudes or hitherto repressed feelings" (pp. 101-102). Davis then proceeds with an imaginative effort at bridging the theoretical gap between classical and modern analysis. He reminds us that the element of surprise which accompanies genuine insight is common both to joining and to classical interpretation. This leads him to conclude that the joining intervention too may be classified as an interpretation, differing from the classical version only in that the one is verbal and the other preverbal. (4) Spotnitz (1976, 1985) attributes the success of the joining process to its intimate associations with the narcissistic transference. The patient perceives joining as support of his innermost impulses and needs. He is thereby induced to let down his guard and enter a narcissistic relationship with the analyst, ultimately leading to the forthright expression of feelings.

We may elaborate Spotnitz's views as follows. The patient has entered treatment with reluctance, suspicious of the analyst, in whom he is prepared to find a personification of societal demands and pressures and ultimately of the omnipotent and frustrating mother figure of early life. Instead, he finds a mirror image of himself, a therapist who supports his negative attitudes and encourages him to maintain and even elaborate his resistance patterns. The patient reacts hesitantly, testing the analyst's good faith with ploys and maneuvers. In the course of developing the narcissistic transference, he gradually comes to accept the analyst as his true double, a figure whose ego matches his own. This unexpected bounty confers a twofold benefit upon him. Since there is nothing to oppose, he can dispense with his negativism or use it for purposes of maturational growth (Kesten, 1955). Furthermore, the twin image of his ego

presented by the analyst serves as palpable evidence that he is not alone, that a kindred spirit shares his view of life and its encounters. This awareness of fellowship signifies an identification with the analyst's ego and a consequent enhancement of the patient's ego. When the process has gone far enough to enable him to feel secure and ready to cooperate with the analyst, the latter helps the patient resolve his resistance to accepting positive goals of growth and maturity.

Another theory, originating outside modern analytic circles, associates the joining technique with the process of projective identification, a concept first propounded by Melanie Klein (1946). Briefly, projective identification is projection with a string attached to it, as it were. The individual who projects, rids himself of an unacceptable idea or feeling by attributing it to another. He spits it out for good. In projective identification, on the other hand, the unacceptable idea or feeling is projected onto another with the intention that the recipient will process the induced feeling through his own personality and make it available in a revised form for reinternalization by the projector. Ogden (1982), describing this process with exquisite clarity, suggests that joining plays out a projective identificatory drama in the following way: (1) The patient externalizes his toxic introject onto the analyst. (2) The analyst joins the patient. (3) This enables the patient to observe and understand himself in the person of the analyst and to reinternalize a detoxified introject now imbued with qualities partaking of the analyst's healthy personality. In Ogden's words, joining is "a way of returning to the patient a modified version of an unconscious defensive aspect of the patient that has been externalized by means of projective identification" (p. 87).

The last word has obviously not been spoken on the meaning of the joining technique. For the time being, we must content ourselves with a variety of often overlapping explanations, while we go about our absorbing therapeutic encounters with narcissism. Sooner or later, theory is bound to overtake us and fully divulge the reasons for our clinical successes.

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Book Reviews

Mutual growth in the psychotherapeutic relationship: Reciprocal resilience. Patricia Harte Bratt. London: Routledge Press, 2019. 206 pp.

Typically, I have had two explicit reasons for seeking supervision: The first, of course, is to deal with subjective countertransference resistances that visit me in the form of unusually intense confusion or dread. And the second is to discharge frustration, as in my responses to some of the more intransigent resistances, so as not to unwittingly contaminate the treatment. But I never recognized, before reading Patricia Bratt's new book, the significance of the fact that both of my reasons for seeking supervision have to do with the patient's needs; I'm always making sure that I'll be in the best condition *for them*.

In Bratt's new book, *Mutual Growth in the Psychotherapeutic Relationship*, what I for one seem to have considered unthinkable finds words: that as much as the patient, the practitioner, too, is entitled to, and should expect to, grow stronger and better as the relationship proceeds. This model of "mutual resilience" challenges the taboo implied within the more commonly held idea that a practitioner is not supposed to have their own issues.

Of course, modern psychoanalysts have long acknowledged, even proudly proclaimed, that "emotional communication" requires, a priori, deep knowledge of our own mental apparatus, and that our training is, by definition, a personally transformative experience. But what if a recognition of our own personal

resilience and growth, in light of our own trauma, became an actual, acknowledged goal?

Writing within a two-part structure with a summative epilogue, Bratt first presents a new framework and model to better embody the therapist's experience, and then provides a host of stories that bring you into that model emotionally. Poring over hundreds of hours of recorded two-part interviews with clinicians working with traumatized patients, Bratt makes and here reports a fascinating discovery: the research interviews themselves seemed to make a difference, for the better, in the clinician's conception of their own work.

Borrowing from George Vaillant's hierarchy of adaptive defenses, Bratt begins conceptualizing her research participants, all therapists dealing with cases of trauma (sometimes very severe trauma) from within the framework of his five charted "mature adaptive defenses": altruism, sublimation, suppression, anticipation, and humor. In what appeared to be a dual and simultaneous process of identifying and then articulating these adaptive defenses to the participants themselves, Bratt notices that when the participants were helped to focus on their own mature defenses, they began to talk about their most difficult cases in a new way—more positively and confidently. Most notably, some of the participants would bring to Bratt's second interview the same case they had brought to the first. Why had they forgotten their original recounting? Because, Bratt hypothesizes, having reframed it according to their own capacities, the case shifts in emphasis and becomes an entirely new, and more personally healing, narrative.

The real heart of this book begins with its second section, the stories of the interviews—which, Bratt assures readers, is a fine place to start, despite the long preamble that sets forth her model and explains her methods and research structure. This second section is framed like a story within a story, using Vaillant's five defenses to organize the participant's stories, and then, telling them.

The stories also often carry their own smaller subsets of interesting information, for example that clinicians engaged in ongoing supervision scored higher than others in their use

of mature adaptive defenses. A refreshing finding, given the (often tacitly) assumed requirement of all modern analysts to control for potential treatment failures mostly by talking to our supervisors and analysts, no matter how "advanced" we become in the practice.

While proposing how to help clinicians build resilience by paying attention to how well we cope with the often agonizing retelling of traumatic events in the office, Bratt's model aspires to help us pay closer attention to our *effective* patterns of coping with difficult clinical material, greater mindfulness of which, she shows convincingly, helps clinicians not only feel better about their work, but also recover from and indeed become detectably stronger as a result of our own traumatic events.

Bratt's model, however, is more than simply a way for clinicians to feel better about their work. Her model for building resilience is based on a deeper understanding: that the clinician will unconsciously repeat, via processes of projection and identification, the experience of their own traumatic events when treating patients. She writes: "The mind is ingenious at organizing situations that compel us to re-experience old conflicts without our conscious awareness that we are echoing the past with a need to master it, or simply be it," she writes (p. 9). With the concept of the repetition compulsion in mind, Bratt's model and case materials bring to light the invaluable opportunity for deep repair and restoration of the clinician's own traumatic experiences. What Bratt proposes is that a new focus be placed on how clinicians see themselves—not only in their patterns of resistance and potential destructivity (the two reasons I typically go to supervision) but also to recognize our patterns of resilience, mastery and unconscious adaptation.

The emotional communications Bratt proposes in her model of the supervision of clinicians go beyond joining their experience, and have as their goal bringing to light and strengthening their adaptive coping mechanisms. For example, she communicates to one of her research subjects: "Even in the chaos, you knew a solution could be organized." (p. 171). Calling to mind the clinician's effective strategies, Bratt maintains, paves the way for the clinician to understand the experience of doing

treatment in a new way; a way that broadens the experience of serving another human being with the promise of self-healing and strength-building. It is an uplifting message indeed.

Readers should venture into this book if for no other reason than to enjoy Bratt's uplifting sense of wonder and compassion for her subjects and for the work itself ("My experience with the research project I am about to describe was one of the most emotionally significant, inspiring adventures in communication and psychic exploration of my professional life. . . . I learned, I grew, I had fun," she writes (p. 19). Through her stories, you can feel the author's openness to and appreciation for the human dimension, and to be uplifted by the message that a clinician's growth and success in developing resilience should not just be an offshoot of our work, but a priority.

Claudia Luiz

Psychoanalysis and anxiety: From knowing to being. Chris Mawson. New York: Routledge, 2019. 217 pp.

Mawson's book situates anxiety and its containment as the foundation of psychoanalytic thought; with anxiety and containment receiving primacy, kinship is sought with philosophical iterations of those concepts. In particular, the book looks at the ancient Greeks and then proceeds to Heidegger and the work of *Daseinsanalysis*. Here, the nature of being is explored and existential anxiety is dealt with in a way not typical of psychoanalysis. Clinical suggestions here ask for a deeper understanding of existential anxiety, through a deeper engagement with what it means to be alive. To be clear, a fear of death could be more than just a repetition of infantile experiences of parental absence, but rather, an essential part of being human, and thus not entirely shaped by early development.

It follows that to elucidate this existential component of anxiety, one must explore the nature of existence itself, and not reduce

all anxiety to a developmental model. While it sounds overly simple, the recommendation here is to just "be-with" existential anxiety. An inability to bear anxiety toward death can lead the analyst into action—anxious interpretation, a restless barrage of questions, a refusal to acknowledge existential anxiety and an itch to get away from it. Being able to just "be there" is a monumental achievement in patience and bravery. It discloses that while being receptive, one also needs to be resolute, and to have faith that the psychoanalytic experience can survive such intensity.

Another link is introduced when Mawson introduces the theatrical element. He considers the performative aspect of behavior to be intimately intertwined with the prepsychoanalytic origins of psychoanalysis, the method created by Joseph Breuer, termed the cathartic method. Mawson views the internal aspects of object relations as inherently theatrical, unfolding alongside the principles of theater, which are human-made principles derived from experience. The point here being that the collective experience of tragedy in the polis was derived from experience, and the working through of trauma in theater is not that disparate from the working through that occurs in psychoanalysis. Of particular importance here is the theatrical atmosphere within the psychoanalytic frame. I think Mawson here is trying to point us toward a dramaturgical component of emotional life. I do not mean this in a pejorative way, as when analysts accuse patients of being "dramatic" or "overly dramatic," but rather, the dramaturgical component within all of us, that emerges in the moments when emotional life rises to the surface and interacts with the other "characters" in the world. What *character* is the analysand trying to induce in the analyst when they present their dramaturgical self? In some ways this could be seen as the essence of a transference communication.

Further considerations of the dramaturgical prompt a look at the theoretical aspect of the theatrical work of Bertolt Brecht —his method of making the strange familiar. Critical distance and insight are achieved by disidentification with the characters, a key difference from the Aristotelian conception of catharsis occurring through an identification with the suffering of the protagonist. This state of mind can provide many clini-

cal benefits if one looks at how analysts make progress with patients. Identifications with the patient through empathy tend to have a containing function, yet identification can prevent insight because the lack of distance can be blinding—can become, that is, overidentification. Disidentification, while less empathetic, provides a larger field of vision and allows one to see things that are invisible during overidentification. Perhaps the juxtaposition of these two theatrical conceptions can elicit a technical suggestion, for the analyst not to be too close or too far away from the internal objects of the patients. Supervision is key here because it creates a third, an audience member to the analytic dyad, thus creating new perspectives, not by any superpower of the supervisor, but simply by being an "audience member" in what may be seen as an intermediary space between the analyst and analysand. Furthermore, it is more than just a dichotomy between extremes, but rather a flexibility, something that can occupy and tolerate a fluid, sometimes expansive and sometimes constrictive atmosphere. Mawson provides many beautiful analogies of the relationship between the emotional experience induced in theater and that of the psychoanalytic situation. He opens paths in which psychoanalysis could learn more from theater. Rather than accepting uncritically the purging notion of catharsis, he emphasizes the process of emotional transformation that occurs in experiencing the performance of a play and understands it alongside the emotional transformations that occur in analysis.

The book sets out to make these very difficult links and I believe some of these links are left unsaturated and have the capacity to become a more intimate conversation between seemingly different fields. One link in particular that I think can be further explored pertains to that between Bion and Heidegger. I would also introduce a third link: the lectures Heidegger gave on Nietzsche. And—at the risk of overcomplicating the present discussion—another situation with Aristotle arises, in regard to the primacy of sensation in the movement toward truth.

This is perhaps an oversimplification, but: Bion, Heidegger, Nietzsche, and Aristotle might be brought together to help us come to a better understanding of "negative capability" and "listening without memory or desire." Negative capability can

be seen as Bion's vast expansion of Freud's notion of "evenly suspended attention." For Bion, negative capability is a state of mind that allows the truth to emerge. It asks analysts to forget their theories, and even goes as far as suggesting that we should no longer trust any sensuously derived thoughts, and even further, to resist the itch to allow these thoughts to be turned into *constant conjunctions*, his term borrowed from Hume referring to the tendency of the mind always to look for causation.

Furthermore, negative capability is a mode of listening, which I argue is a sensual mode of being and the main starting point for any movement toward truth. Thus, truth is always sensually derived. Bion (1977) also reminds us that for Freud, "The psycho-analyst and his analysand are alike dependent on the senses, but psychic qualities, with which the psycho-analyst deals, are not perceived by the senses but, as Freud says, by some mental counterpart of the sense organs, a function that he attributed to consciousness" (p. 28). What Aristotle contributes to this is that he avoids the dichotomy that Bion and Freud seem to imply. Aristotle sees the senses as the foundations of thought and does not seem to recommend their abandonment in the movement toward truth—in his case, the movement toward the universal. Sensation is irreplaceable, the ground or "home" in which all thought emerges. Thus knowledge arises through recognition and remembering information obtained through the senses. Beings relate to other beings in this way, motivated by desire that runs through a basic passivity and receptivity to alterity. Humans receive the world through this fundamental passivity. Our positive capability emerges when we bring experiences together and identify recurrences of the same. One can never be rid of memory and desire, but a look at the grounds of such an occurrence creates many opportunities. Both Aristotle and Bion explore the origins of thought; I think a key difference is that with Aristotle, we do not have the superego's prohibitions against memory and desire. Like Socrates' treatment of the poets, Bion puts aside memory and desire, to allow their return at a later, more evolved point. Bion's main critique is that theory can act like Hanna Segal's "symbolic equation," preventing us from "seeing" what is happening in a session because we have replaced the patient with a theory. Like an infant who sucks on

a fantasy, an analyst can block experience by feeding on what they already know.

I think there is some philosophical confusion in Bion that it might be helpful to elucidate. The confusion arises when Bion seems to equate sensation with knowledge derived from the senses. After the prohibition is introduced, what is mostly attacked is the habit of thought, and not necessarily the faculties of sensation. Furthermore, desire and memory are not really suspended; what is suspended pertains to the habits of thought derived from memory and desire. Mawson shows how Freud wanted us to suspend attention evenly and not feed memory with information that it finds familiar. The question is whether this is really a suspension of the senses; it appears rather as a reorientation of the senses, away from habit and toward the grounds of habit, which is always experienced through the senses. When Bion suspends memory and desire he is able to "see" (sense) that his patient senses that his socks are really just a series of dangerous holes. What has been suspended is not the realm of sensuality but rather the realm of habit, particularly the habit of seeing socks as merely socks. Bion goes further and is able to "see" that the holes are not psycho-sexual phenomena, but rather the primordial holes of existence.

Mawson via *Daseinsanalysis* gives us another opportunity to escape habit by introducing us to a new (though actually older) conceptual model of existential anxiety. Here, the patient who can only see holes is not pathologized. Mawson sees that this patient can see some truth about the nature of existence: that we all die, and thus that the truth of nothingness is behind every positive formulation, and though frightening, is one of the motive forces of desire. Thus, interestingly, Bion negates desire and sees that the patient sees nothingness. What is sensed here is perhaps some foundational truth that cannot be filled with positive knowledge and readymade psychoanalytic interpretations. Mawson suggests merely "being with" this particular form of anxiety. There is no cure for it other than sharing its experience, and just being with the patient. Without the philosophical perspective, the analyst will have trouble letting this anxiety simply be. One needn't either evacuate it or fully know it, but rather accept it and be brave enough to experience it.

When Bion advocates ridding oneself of memory and desire, he speaks of greed and saturation; the problem does not seem to pertain to sensation. One cannot escape sensation, and one must question why this escape is to be desired. Bion is unclear on this point. At times he speaks of things derived from sensation as obstructive, but at the same time he qualifies this notion when he states that, "If he is able to be receptive to O, then he may feel impelled to deal with the intersection of the evolution of O with the domain of objects of sense or of formulations based on the senses" (p. 32). Thus, once negative capability is sustainable, a return of sensation and sensually derived ideas are allowed to emerge. For those unfamiliar with Bion: he uses the letter "O" to designate what he terms "ultimate reality"; this ultimate reality is unknowable, according to Bion. However, he sees everything as moving toward O and he believes you can have an experience with O, even though you can never know it or possess it. The "O" of the session pertains to the unique truth, specific for both analyst and analysand, that emerges throughout treatment. Defenses against "O" can operate in both analyst and analysand, which most psychoanalysts would know by the term resistance. Bion's pathway toward an experience with O is through *negative capability*. He borrows this term from Keats, who, in a letter to his brothers, credited Shakespeare as being the most capable of thriving in states of uncertainty.[1] One can liken this to what Bion refers to as listening without memory or desire. The emotional state created by the analytic situation often moves the analyst toward a hatred of uncertainty, born of a discomfort with uncertainty. This discomfort is experienced as frustration that is akin to a state of pain, perhaps not dissimilar to the pain that is standing in as a substitute for truth.

Bion notes that the last operation is only possible through faith, which I would like to link with Aristotle's notion of trust. Bion requires faith to sustain the process of negative capability. Without it one would be left with aimless dread; thus one must be-

1 "I had not a dispute but a disquisition with Dilke on various subjects; several things dove-tailed in my mind and at once it struck me what quality went to form a Man of Achievement, especially in Literature, and which Shakespeare possessed so enormously - I mean Negative Capability, that is, when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason" (Quoted in Bion, 1970, p. 125)

lieve on some level that things could be better even though that future is not available to us. Aristotle, in situating induction from the senses as the primordial ground of knowledge, also recommends trust as a foundational concept. Thus Bion's faith and Aristotle's trust would lead to an interesting discussion because they both deal with the movement toward knowledge.

Mawson's book opens up many opportunities for further growth. The book brings in and encourages an engagement with fields outside of psychoanalysis. Not many authors can accomplish such a difficult multidisciplinary undertaking; I think it is perhaps Mawson's desire for truth, inspired by Bion, that takes him to the world outside of psychoanalysis. This is also the intellectual spirit of Freud, who integrated medicine, Greek mythology, theatre, biology, and philosophy in his pursuit of new psychoanalytic truths. Thus, the "outside" no longer remains without, but speaks to the foundational, multidisciplinary home of the psychoanalytic endeavor.

Paul Moore

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Lawrence Epstein was a training and supervising psychoanalyst and faculty member at the William Alanson White Institute, and clinical professor of psychology in the postdoctoral program for psychotherapy at Adelphi University. He was co-editor and a contributing author of *Countertransference: The Therapist's Contribution to the Treatment Situation*. He also published widely on the therapeutic use of countertransference with difficult patients. His private practice was in New York City.

Evelyn Liegner was a founder, faculty member, training analyst, and supervisor at the Center for Modern Psychoanalytic Studies (CMPS), a member of the National Psychological Association for Psychoanalysis (NPAP), a member of the board of directors for Society of Modern Psychoanalysts, and a member of the board of trustees of CMPS. Her monograph *The Hate That Cures: The Psychological Reversibility of Schizophrenia*, published in *Modern Psychoanalysis* as Volume 5 was a foundational clinical paper in the treatment of psychosis. She practiced in Great Neck, NY.

Benjamin Margolis was a founder, faculty member, and dean of students at CMPS, where he also sat on the board of trustees. He was a founder, first corresponding secretary, and a training and control analyst at NPAP; faculty member of California Graduate Institute; and an adjunct professor at the Union for Experimenting Colleges and Universities. A collection of his papers on modern psychoanalytic techniques was published as

Vol. 19, No. 2 of *Modern Psychoanalysis*. His private practice was in New York City.

Phyllis W. Meadow, the founding editor of *Modern Psychoanalysis*, was the founder and director of CMPS and of the Boston Graduate School of Psychoanalysis. She was the author of many papers in *Modern Psychoanalysis*, and the books *The New Psychoanalysis* and (with Hyman Spotnitz) *Treatment of the Narcissistic Neuroses*. She practiced in New York City and in Boston.

Hyman Spotnitz was honorary president of CMPS, and a central figure in the study and understanding of the borderline patient and preoedipal disorders, beginning with his work at the Jewish Board of Guardians in the 1940s. He was the author of *The Couch and the Circle: A Story of Group Psychotherapy; Modern Psychoanalysis of the Schizophrenic Patient: Theory of the Technique; Psychotherapy of Preoedipal Conditions: Schizophrenia and Severe Character Disorders;* and co-author of *Treatment of the Narcissistic Neuroses*. His practice was in New York City.

Barbara D'Amato, PsyaD, LP, is on the faculties of CMPS and the New York Graduate School of Psychoanalysis (NYGSP). She is director of the CMPS distance learning program. She has written and presented on treatment of adolescents, emotional communication, dreams, education, and psychoanalytic perspectives on literary characters and authors. She maintains a private practice in Manhattan and Brooklyn.

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Marcus M. Silverman, MA, LP, NCPsyA, an associate editor of *Modern Psychoanalysis*, is a psychoanalyst in private practice in New York City. He studied philosophy at Sarah Lawrence College and psychoanalysis at CMPS and NYGSP, where he is now a faculty member of both. He is also on the faculty of the Manhattan Institute for Psychoanalysis.

Jane Snyder, PhD, is the president of BGSP, where she teaches, supervises and practices psychoanalysis. She is the author of a comprehensive account of the theory and techniques that constitute and define modern psychoanalysis in relation to other schools and bodies of psychoanalytic theories and techniques (in *Modern Psychoanalysis*, V. 50, no. 2, 2015).

Remembering Evelyn Liegner

We are very sorry to announce the death of one of the last remaining founders of CMPS, Evelyn Liegner, on April 5th. Dr. Liegner was among the group of analysts trained by Hyman Spotnitz who joined under the leadership of Phyllis Meadow to organize and develop the Center for Modern Psychoanalytic Studies in 1971. She taught primarily at CMPS, but also traveled to the Boston and Vermont campuses to contribute her clinical expertise (and her warmth and wisdom) to those programs.

Dr. Liegner was a valued member of the CMPS Board of Trustees and a generous contributor in a multitude of ways to our school, and to the body of theory and technique that constitute modern psychoanalysis. Her published articles included the especially influential "The Hate that Cures: The Psychological Reversibility of Schizophrenia." A collection of her invaluable papers constituted Volume 28(1) of *Modern Psychoanalysis*.

Evelyn Schnayerson was born in Babrousk, Russia, on September 23, 1922, and came to the United States with her family at about age three. Both she and her husband of 71 years, Leonard Liegner, were central to the beginnings and early development of CMPS. (Leonard Liegner, a radiologist, taught courses on the brain at our school, and once defied various regulations—not ours; the center hadn't thought to address the issue—by bringing an actual brain to one of his classes. His death occurred in 2012).

Those of us who had the privilege of working with Evelyn Liegner will warmly remember many things about her; I will miss, not only but especially, her wit, her clinical acumen, her ability to confront and challenge me without criticism. Dr. Liegner never ran out of the next question to be asked.

Faye Newsome

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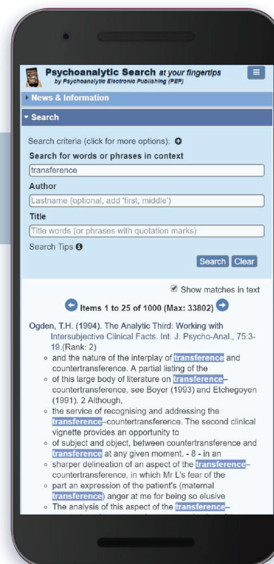

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