Margolis, B.D. (1994). The Contact Function of the Ego: Its Role in the Therapy of the Narciss... Mod. Psychoanal., 19:199-210.

Modern Psychoanalysis

(1994). Modern Psychoanalysis, 19:199-210

The Contact Function of the Ego: Its Role in the Therapy of the Narcissistic Patient

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A Bridge to the Object

The ego has been described as a substructure of personality defined by its functions **(Hartmann, 1950)**. Among these, **Freud (1933)** especially emphasized the importance of the functions that are directed toward reality, i.e., toward objects, representing the urge toward need- and wish-fulfillment. A conceptualization of this aspect of ego development has emerged in recent years in the writings of Hyman Spotnitz and his co-workers (Spotnitz, **1961**, **1963a**, **1963b**, **1967**, **1968**, **1969**, **1976**; **Spotnitz & Meadow, 1976**; **Spotnitz & Nagelberg, 1952**; Spotnitz, Nagelberg, & Feldman, **1953**, **1956**; **Borowitz, 1978**). Out of their experiences in treating narcissistic patients, they have identified a *contact function* of the ego which reflects the person's capacity to perceive an other, to reach out to him, and to establish a relationship with him as object. As **Spotnitz (1963a)** defines it, the contact function represents "the patient's … direct attempts to elicit some personal information about the analyst or to involve the analyst in some emotional problem he is unable to express in words" (p. 54).

The term "contact" in the context of psychic development was introduced by Winnicott in 1945, when he stated that "at the start a simple *contact* with external or shared reality has to be made [by the infant]" (p. 154). The term was further employed extensively in

Winnicott's article "Paediatrics and psychiatry" **(1948)**. Later on, **Winnicott (1949)** and **Guntrip (1961)** described a behavioral interchange between mother and neonate that may represent an early rudimentary expression of the contact function and the response to it, and that may establish the model for its further development. Speaking of the infant's need for a perfect environment, Winnicott says: "The perfect environment is one which actively adapts to the needs of the newly formed psyche-soma. A bad environment is bad because by failure to adapt it becomes an impingement" (p. 45). Guntrip, elaborating on this theme, states:

> *This "perfect" environment is provided by the mother who actively adapts to the infant's needs as they develop and are expressed. Here maternal intuition recognizes and provides what the baby wants and when he wants it … Active adaptation is response to the baby's own initiative in "seeking" (italics added). (p. 400)*

Thus, the earliest relationship between mother and child begins with the infant's expression of need and "seeking" behavior, which sets off the mother's response of active adaptation. **Spitz (1965)** similarly describes how the baby is compelled by hunger "to seek" nourishment. In an earlier paper **(1955)**, he uses the expression "turning toward" to describe this phenomenon.

Closer to home, in the framework of analytic therapy, **Loewenstein (1956)** has drawn attention to Buehler's classification of speech according to its functions. Of particular interest here is the function of appeal, which is described as encompassing "all those speech acts which appeal to the addressee to do something or to respond in some way" (p. **462**). Loewenstein adds that in the analytic setting "the appeal function … manifests itself as transference reactions" (p. **462**).

This brings us close to Spotnitz's formulation of the contact function, a concept born in the crucible of analytic therapy with narcissistic disorders, and associated with the dynamics of the treatment process. The contact function is the operational means by which the patient creates a bridge to the object through the development of the narcissistic transference. Later in this paper, we shall describe the emotional ramifications of this process, leading to the observation that the contact function also embraces the dimension of affect in object relations.

Making and Maintaining Contact

The contact function (often referred to in the active mode as "contact functioning") appears in two forms. (1) *Making Contact*. Is the patient able to "crack the ice" and initiate an approach to the analyst? (2) *Maintaining Contact*. Once contact has been

established, to what extent is the patient able to sustain emotionally significant interchanges, predominantly investigative in nature, with the analyst?

Making Contact

This is the basic form of contact functioning. It represents the first stirring of long-frozen feelings, set in motion by pressures of the analytic process. Two motives, one negative and the other positive, cooperate to inspire the movement. The more primitive (and negative) of the two is flight from danger. The analyst's instruction to talk confronts the patient with the monumental task of putting aside his narcissistic defenses and exposing the complex of feelings he has successfully concealed all these years. What better way to avoid this than by focussing attention on some external object, perhaps the analyst himself; e.g., Why is it necessary to lie on the couch? How will talking help? Why doesn't the analyst say something? On the positive side, the analytic situation, with the patient lying passive on the couch and talking and the analyst sitting behind him, exerts a powerful regressive pull, which the patient both resists and surrenders to. Something uncannily reminiscent stirs within him, a need for objects that stems from an earlier period of life. Never mind talking about himself, here is an opportunity to gratify "in the flesh," as it were, a craving whose existence he had hitherto denied. An inner struggle ensues. Sooner or later he compromises by making diffident contact with the analyst.

Maintaining Contact

What happens once contact has been established? How does the patient deal with the analyst's response? The most rudimentary reaction is to break off further contact. The patient falls silent, or he goes back to his indeterminate ramblings. A step above this is for the patient to change the subject and make contact with the aid of a new topic. Periodically, the patient makes such a cluster of contacts, moving from one topic to another and never staying with one contact

beyond a single exchange; e.g., *Patient*: What shall I talk about today? *Analyst:* What is there to talk about? (Pause) *Patient:* Is this the day I pay you? *Analyst:* What day is payment due? (Pause, followed by another change of subject.) From this point forward, development in a maintaining contact takes the form of increasingly extended investigative dialogues with the analyst. By way of examining the uses of the contact function, we turn first to its role, at the beginning of treatment, in establishing the extent to which the patient is narcissistic or object-oriented.

Determining the Degree of Narcissism

The degree of exposure to frustration-aggression experienced in early childhood varies with the individual, as do the defensive measures taken to cope with it. The end product of these formative experiences is a complex, sometimes skewed, ordering of structures associated with ego identity and object relatedness. When the development is uneven, marked by excessive frustrations, unwholesome introjections and attendant arrests, a unique condition of imbalance comes to characterize the narcissistic personality. This takes the form of a tentativeness in the level of ego identity attained by the individual, so that self and object, at times symbiotically confused, may at other more propitious moments stand out fully individuated.

Patients with this kind of psychic configuration are more often likely to appear in the analyst's office than those with more extreme personality distortions. How to begin treatment with such patients? The analyst's first task is to determine the relative proportions of narcissism and object relatedness in the patient, less as an exercise in diagnosis than in order to determine what procedures to use in the initial phase of therapy. One rough but serviceable method for accomplishing this is to note the degree of contact the patient establishes with the analyst. The patient's contact functioning, as we have learned, reveals itself in two ways. (1) Is he able to make contact and initiate give-and-take with the analyst? The more self-absorbed the patient and the less such contact, the more narcissistic he is. (2) If he does make contact, e.g., by asking "Why is the couch important?" then how does he maintain contact, i.e., how does he deal with the analyst's response, "Why is the couch important?" The analyst does not supply information. He is trying to discover what level of development his patient has reached. Can he answer questions reasonably or is he too infantile to do so? The manner in which he deals

with the analyst's questions defines the manner in which he deals with the analyst, who is the object. A direct, concrete answer ("I can relax while I talk.") establishes direct, concrete contact with the analyst. The patient is capable of unambiguous involvement with objects, its extent subject to further assessment. A vague answer ("There must be a reason for it.") or a self-absorbed one ("I have a couch like this at home."), or silence, denotes the patient's poverty of contact functioning, his unrelatedness to the object. In true narcissistic fashion, he retreats into himself Thus, the extent to which the patient makes and maintains contact, and the quality of the contact, may provide some measure of the degree of narcissism or object relatedness in the patient.

Its Role in the Therapeutic Process

An important part played by the contact function is that of guide to the perplexed, who is none other than the analyst. The narcissistic patient at the beginning of treatment is an enigma wrapped in a conundrum. His tolerance level for frustration-tension and his tendencies toward impulsive action are unknown. Perhaps the analyst's mere presence already verges on the intolerable for him. Shall the analyst speak or remain silent? If he speaks, when shall he do so, and what shall he speak of with the certainty that he is not precipitating treatment—destructive resistance or psychotic regression in the patient? Trial and error are hazardous in these circumstances. Willynilly, he remains silent. It is then that he discovers the value of the contact function. Left to his own devices, the patient often attempts to make contact with the analyst by asking a question. The scene is set for the analyst to speak without hazard. He need merely deal with the patient as narrowly as prescribed by the patient's question, which defines and controls the degree to which the patient is ready to be stimulated without suffering undue stress.

As we have observed, the reasons the patient makes contact are themselves significant for the analysis. From a practical standpoint, the patient has obviously shifted attention from himself to the analyst. Instead of talking about his own thoughts, feelings, problems, he asks the analyst to talk, but on a topic of the patient's choosing. There must be a reason for this. The first explanation that comes to mind is that the patient finds talking about himself disquieting, and his attempt to shift the burden of talk to the analyst is a maneuver of avoidance, a form of flight from his own feelings. The analyst

is thereby alerted to a defensive pattern that will manifest itself throughout the treatment.

On another level, the patient's effort to establish contact with the analyst has been seen as the expression of a hunger for objects. He wants to move out into the environment, to reach out to an other. It is an object-oriented, self-expanding move. Whatever the question, the patient is not really interested in a factual answer. He is saying: I need, and I perceive you as the supplier. The need is emotional, a hunger for connection with a not-I of sorts, and patterned on the infant's need for the breast. As a tentative overture to reality, now represented by the analyst, it initiates the unfolding of the narcissistic transference.

How does the analyst respond to the patient's move? He recognizes that, in making contact, the patient is signalling him to talk. He accepts this as a timing arrangement for communication. The patient is the best judge of his own capacity for receiving stimuli without tension overload. Thus, when he makes contact, the analyst may safely respond with an intervention which is appropriate both in its timing and in its content.

The analyst's intervention gratifies the patient on several levels of need. By the fact that he briefly assumes the role of speaker, he spares the patient for the moment the stress of experiencing his own psychological person, whose intense feelings of hate and love he is not as yet prepared to perceive. At the same time, the analyst meets the patient half-way in his reaching out toward reality, materializing, in his response, as the object the patient is groping toward. On a deeper level, he provides the patient, in his role of supplier, with “brief verbal feedings on a self-demand schedule” **(Spotnitz, 1969)**. These are different ways of describing an interchange, initiated by the patient and reciprocated by the analyst, which heralds the beginning of mat-urational advance for the patient. The analyst is inevitably involved as ego-syntonic object in this process.

If we look at the last statement more closely, we are struck by an anomaly. The way the analyst responds to the patient's attempts at contact is to reflect his questions with questions of his own. He assumes an investigative stance and explores with the patient the reasons for the questions, and what kind of response he would like to have, and the reason for that. In thus reflecting the patient's questions, the analyst is providing him with the object he craves. But it is a very special kind of object, one who asks questions exactly as the patient does, timed to the patient's invitations to speak and focussing on the topics the patient prescribes. One is bound to conclude

that the analyst is at once a separate object and a twin image of the patient. Observed through the patient's eyes, the analyst offers a comforting sight, indeed. The patient sees his double, a figure like himself, whom he can love and hate as he loves and hates himself. He can summon him to his side when he needs support against destructive impulses within himself, and he can revile him when he feels like reviling himself.

A Gauge of Analytic Progress

Another role of the contact function is that of measuring progress in the analysis. This is best observed in the treatment of more primitively arrested patients who continue in their self-absorbed state and, unlike those described in the preceding section, avoid making contact with the analyst. These patients behave as though the analyst did not exist. They commune with themselves in long monologues—if they speak at all—and when the analyst tries to intrude, they brush him off with a short, uncommunicative response. One measure of progress in the analysis is the extent to which the patient gradually moves away from this position and turns his attention toward the analyst. The development of the contact function thus becomes a criterion for evaluating analytic progress.

How does the analyst go about helping the withdrawn patient develop contact functioning? Let us visualize a representative situation. The patient has recently entered therapy. Following the analyst's initial instructions, he lies on the couch and talks. But he

talks only to himself. He directs no questions to the analyst. He makes no contact with him. We have already seen how unnerving such a situation can be to the analyst. After studying the patient for some time, the analyst himself finally sets about making contact, with the intention of creating a model for the patient. This is a most delicate operation which is undertaken only with the patient's permission. (“May I ask a question?” “Yes.”) From time to time, then, not too often at the beginning, the analyst asks a simple, object-oriented question. What time of day was that? What was the man's name? Where did this take place? As session follows upon session, the patient forms an impression or develops an introject, if you will, of the analyst asking questions, and himself begins to do likewise, directing questions to the analyst.

Later on, and in conjunction with this technique, the analyst might try another. After the patient has spoken at length without contact,

the analyst says: “You have spoken of a number of things today. Is something expected of me in connection with what you've been saying?” Whatever the patient's reply, it enables the analyst to engage him in an interchange, thus helping the patient to develop the capacity for making and sustaining contact. The analyst tries to sensitize the patient to the fact that, in talking, he is making a series of communications to an individual distinct from himself, from whom he may elicit responses.

A bolder technique for promoting the contact function waits upon the patient's partial emergence from his introverted state. The analyst has already vaguely begun to take shape as a separate object in the patient's perception—witness the sporadic questions and occasional personal comments directed to the analyst. It is now possible, without overwhelming him, to make a full-face presentation to the patient of the analyst as object. Reacting to a story the patient has told, the analyst asks, “Am I like that?” or, “Would I do that sort of thing?” or “How do I measure up, by those standards?” This technique is based upon an assumption that is therapeutically rewarding, if less than strictly verifiable in fact, that, no matter whom he is talking about, the patient in a narcissistic transference and when not engaged in progressive communication is talking about the analyst. The outside objects he depicts are analyst-proxies—or displaced transference objects—toward whom he expresses feelings intended for the analyst. This is so because the patient's universe in the narcissistic transference duplicates the original symbiotic mother-child universe, and whatever he speaks of, in the end he speaks of himself and the mother object, represented by the analyst. Therefore, whenever (in the restricted circumstances mentioned above) he speaks of some outside individual, it is a resistance which is periodically dealt with by asking how the analyst comes off in such a situation, thereby redirecting the patient's attention to the patient-analyst relationship.

The interchanges promoted by this latter technique require a high order of ego functioning on the part of the patient. There has been a substantial advance from the initial modeling by the analyst of the mere act of making contact to the present exploratory dialogue, in which the patient is able to maintain prolonged contact with the object. Needless to say, progress of this sort in the development of the contact function is accompanied by the unfolding of the narcissistic transference. We are reminded again of the insoluble ties that unite contact functioning with the narcissistic transference, as they develop together from rudimentary to more advanced maturational levels.

The Contact Function as Resistance

The contact function serves as a form of resistance in the therapy, specifically resistance to communication. This statement seems at odds with the picture of the contact function detailed above. The withdrawn patient, in an effort to move away from his self-imposed isolation, has been described as making contact with the analyst. He does this by means of a verbal communication which elicits a response in kind from the analyst. If contact is maintained successfully, the communication between the two gradually ripens into dialogue-like sequences that are of great value in developing the narcissistic transference. How does this constitute resistance?

This is not the place to expand on the well-known phenomenon whereby indispensable components of the analytic process also fulfill a resistance function. We merely observe here that, were an ideal situation to prevail, the equally ideal patient would tell the story of his life without repeating himself, and there would be no resistance (and, of course, no analysis). In the real world of therapy of the narcissistic patient, progressive communication of this kind comes in spurts, starting from a minimum and gradually increasing in scope as the analysis proceeds. When the patient is not engaging in progressive communication, he is resisting. One way of resisting is by making verbal contact with the analyst. As we saw in the preceding section, the patient, in making contact, has among his several purposes a flight from experiencing his own interdicted thoughts and feelings, by inducing the analyst to do some of the talking. Clearly, the contact function, in its role of disruptor of progressive communication, is an architect of resistance *par excellence*.

An interesting feature emerges when we become aware that at least two different forms of resistance are at work here. As against the ideal of uninterrupted progressive communication, the withdrawn patient who indulges in long silences punctuated by complaints and expressions of discontent, is exhibiting the most complete and primitive resistance. Not only is he avoiding telling the story of his life, he does not seem to recognize that the analyst is present in the room with him. He is, as we like to say, at an objectless

maturational level, and his resistance reflects this state by taking a form that antedates the development of the contact function. Later on, when the patient has advanced emotionally to the point where he begins to make contact with the analyst, he is, in doing so, still resisting to tell the story of his life. This time, however, the vague outlines of an object or part

object begin to obtrude. We might say that he goes from one form of resistance to another, from an earlier, more primitive form to a later, more advanced form. To be sure, the purpose of the different resistances remains identical, to avoid talking about himself But the earlier resistance accomplishes this by centering the patient upon himself, without the availability of the contact function and without hope of salvation. He is like the helpless infant who, his cries having gone unheeded, withdraws with all his hunger, frustration and rage into sleep or into a semicomatose state. The more advanced resistance involving the contact function, on the other hand, while also serving the aim of avoiding progressive communication, accomplishes this by addressing itself to the analyst, thereby contributing to the development of the narcissistic transference.

As we see, the contact function creates resistances to communication. It is the patient's manoeuver to avoid talking about himself. The more the contact function develops, especially in the form of maintaining contact with the analyst, the more it blocks progressive communication, which is necessary for fostering the preoedipal patient's maturational growth. Yet the contact function helps build the narcissistic transference, which also fosters the preoedipal patient's maturational growth. There seems to be a contradiction.

The solution depends upon the meaning of the term "communication." When we say the contact function creates resistance to communication, we mean specifically progressive communication, that mode of discourse in which the narcissistic patient freely narrates fresh elements of his life history, with genuine feeling and without repeating himself. But there are other forms of communication as well. The question that the patient poses to the analyst in making contact is a communication. The analyst's response in the form of a question is also a communication. The mode of discourse here is interlocutory, a series of exchanges between two persons on a topic of common concern. It follows that contact functioning serves simultaneously as a resistance to *progressive communication* and as a vehicle for direct verbal communication with the analyst. Both forms of communication help promote the patient's emotional growth. When the patient makes contact with the analyst, the latter's interventions in the ensuing dialogue resolve the resistance, build the narcissistic transference, and liberate the patient to proceed with progressive communication. When the patient proceeds with progressive communication, he recalls and gives voice to archaic thoughts, fantasies and yearnings that remember his earliest years. He can do this only in limited offerings. With the upsurge of powerful, hitherto

repressed feelings associated with the frustrations of that early period, uneasiness soon takes over. The patient enters a resistance phase. If all goes well, his resistance takes the form of contact functioning, as he turns to the analyst for surcease from disquieting feelings and destructive impulses. There follows further development of the narcissistic transference, which denotes mobilization and release of negative and positive feelings, and resolution of the resistance to progressive communication. The patient then enters a more extended phase of progressive communication. Thus, the analysis of the narcissistic patient proceeds by means of alternating episodes of communication that derive from two contrasting modes of discourse and that entail the repeated rise and resolution of resistance.

The events described above present in schematic outline a complex process that is never quite the same for each individual. Patients begin treatment at different levels of contact function distinctive for them. The analyst, if he deems it advisable, may sometimes address the patient without waiting for contact. Relapses may occur, treatment-destructive and other forms of resistance may bring treatment to a halt for weeks on end, and looming termination may produce unexpected regression. There are no simple answers to these problems. The analyst treating the narcissistic patient works with whatever therapeutic means are at his disposal, among them the contact function of the ego. Generally speaking, awareness of the nature of the contact function and the anatomy of its role in therapy contributes to clarification of the clinical process and furthers the search for uniformities in the treatment of the preverbal patient.

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Article Citation [Who Cited This?]

Margolis, B.D. (1994). The Contact Function of the Ego: Its Role in the Therapy of the Narcissistic Patient. *Mod. Psychoanal.*, 19:199-210

