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Drive Theory in Diagnosis and Treatment*

Phyllis W. Meadow, Ph.D.

In thinking about severe emotional illness, modern analysts have come to view the solutions patients use to deal with their emotional conflicts to be 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 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

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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

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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 its 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

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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

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> 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 dimensionterrifying 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.

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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.

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Diagnoses Reevaluated

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,

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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

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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

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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-multilation, 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

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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 some day 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,

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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 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

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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

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> 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

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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 im-pulsivity. 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,

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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 defensivencss, 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

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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

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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

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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 repetitivcly

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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 something 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?

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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.

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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?

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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.

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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 docs. 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 it 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

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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

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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.

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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 understand 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

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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 revealed 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?

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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 extra marital 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.

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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.

References

Clevans, E. (1976), The depressive reaction. *Mod. Psychoanal.* Vol. 1, No. 2, 139-147 [→]

Spotnitz, H. (1969), Modern Psychoanalysis of The Schizophrenic Patient. New York: Grunc & Stratton.

Spotnitz, H. & P.W. Meadow (1976), Treatment of The Narcissistic Neuroses. New York: Manhattan Center for Advanced Psychoanalytic Studies.

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