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How We Aim to be with Patients

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Historical Perspective

1976 saw the publication of two texts, one by Hyman Spotnitz, *Psychotherapy of Preoedipal Conditions*, and one by Hyman Spotnitz and Phyllis W. Meadow, *Treatment of the Narcissistic Neuroses*. These volumes updated modern analytic thinking on the treatment of narcissistic disorders, including Spotnitz's special interest in the psychotic character structure. My contribution to the second volume was to prepare two chapters on theoretical considerations, “Dream analysis” and “Diagnosis re-evaluated,” and three chapters on technical considerations, “The treatment partnership,” “The analyst intervenes,” and “A case study,” on what happens between patient and analyst to bring about change. The conclusions: Only when the analyst can help the narcissistic patient develop an emotional relationship, in other words, a transference, can the patient be cured by analytic work. It is the emotional connection with the analyst that helps the patient to stay in treatment when feelings are painful; establishing that connection means overcoming powerful resistances.

Today I would like to update my thinking on how I try to be with patients, and perhaps say something about why I believe that this approach works. Also I would like to mention briefly the history of modern psychoanalysis and give those who are not familiar with modern psychoanalysis, some idea about what it is. Spotnitz's work in the late forties with adolescent girls, mothers, and children led to his first theory: that the fragile ego needs to be insulated in the analytic sessions and that this cannot necessarily be accomplished by kindness and supportive interventions. Spotnitz presented his understanding

of severe regression to the American Psychiatric Association in 1949. He described a way patient's feelings influence the analyst to repeat the patient's pathological history and offered some thoughts on how we might work with those feelings. By 1950 others such as Margaret Little, Donald Winnicott, and Heinrich Racker were writing about this phenomenon, and analysts were beginning to discover the usefulness of countertransference reactions in work with preverbal fixations.

By 1968 most therapists had become aware that existing theory was not sufficient to explain change in many of the patients then being treated. That year, the American Psychiatric Association's Diagnostic Manual revised its categories to deal with the confusion in the field about the recognition and treatment of the disorders physicians were increasingly being called upon to understand, and a wealth of literature was produced to re-evaluate treatment with narcissistic disorders, including works of Klein, Kernberg, Kohut, Searles, and Spotnitz.

In 1969, some twenty years after his initial publications in this field and many papers later, Spotnitz published his research and conclusions on the treatment of schizophrenia by analytic method in a volume entitled *Modern Psychoanalysis of the Schizophrenic Patient*. In it, he described the role of aggression in the psychotic personality structure and outlined a method of treatment for working with five levels of resistance: treatment-destructive, status quo, resistance to progress, resistance to teamwork, and resistance to termination. His major contribution in this work was to demonstrate how bottled-up aggression led schizophrenics to protect object impressions by turning destructive impulsivity inward.

Modern psychoanalytic theory begins with the notion that transference is possible with people suffering from psychotic and narcisistic disorders, but only under special conditions. Two assumptions formed the basis for modern analytic theory:

1. Destructive impulsivity is the dominant force in the preverbal personality. It is in response to this force that a psychotic defense structure is erected. In the beginning of an analysis, the patient will avoid experiencing longings and will appear not to want a relationship with the analyst. The analyst then has the job of creating an environment in which wishes and impulses can surface;

2. analysts experience their own regression when working with regressed patients, that is, they are contaged by the destructive impulses buried in the patient's personality. More than that, while

working with an individual defended against destructiveness, the defenses of the analyst are threatened, making it possible for the analyst's primitive destructiveness to emerge along with his own primitive defenses, which temporarily override secondary defenses. The controls against impulsivity that the analyst has developed as he matured are seriously challenged in work with today's patients.

Analysts learned that their feelings are both the primary problem and a valuable tool. The analyst copes with tensions aroused in him-he must understand these tensions in order to experience what the patient is experiencing, how the patient is responding to the therapist, and what the patient feels about the general therapy situation. Being with a patient who is coping with his own tensions increases the analyst's understanding of how the patient has created defenses to cope and how libidinal or constructive forces are used in the process. The analyst's flow of thoughts and feelings fluctuates between understanding what the patient is capable of arousing in the analyst and what is being aroused in the patient by the stimulating external presence of the analyst, and what is being aroused in the patient by the session itself which focuses the patient's attention on stimulation from within. The analyst constantly reminds himself that the analytic encounter is a meeting between two rational and two irrational people, neither one fixed in perfect mental health with perfectly stable mental structures, but two persons who, though they may differ quantitatively, will be regressing together in the treatment process and returning together in a journey which reminds me of all the hero-myths that I have read. In *Treatment of the Narcissistic Neuroses* and in his other writings, Spotnitz has related the travails of patients to the journeys of Narcissus, Oedipus, and Ulysses.

The depth to which this journey will take us is a function of the nuclear conflicts in the patient's personality. Each patient is capable of going all the way. Analysts who work with long-term patients know this work takes them to the deepest, most regressed levels, the period of life in which nuclear conflicts developed, prior to the existence of stable psychic structures. Unlike the conflicts seen in children after the development of a language that integrates experience, in earlier fixated cases we experience conflicts between impulses fighting for dominance, conflicts within, rather than between, psychic systems which are without a formal language. We observe patients in life and death struggles, constructive impulses pitted against destructive forces, with the patient attempting to preserve the fledgling ego structure, using primitive mechanisms to resolve

the conflict. Patients split good and bad impressions, projecting the one part while assimilating images and impressions that the ego can accept.

As I read about modern psychoanalytic developments from the 1940s through 1955, the year in which I began my training, I developed the conviction that growth can occur only when the patient is allowed to say everything as he perceives it to an analyst who listens and raises questions without judging or evaluating the patient's perceptions. I don't find this easy to do, particularly when I see a patient getting into trouble from the point of view of my value system. I am a teacher by nature, and an explainer, but when I succeed in sitting with the patient's perceptions, entering the world of the patient, I find the patient improves.

At last year's NAAP conference (1988) those present had the opportunity to watch Spotnitz supervise students reporting their work with narcissistic patients. We saw him counterpoint acceptance of the student's perceptions with the possibility that countertransference feelings were leading to actions that might be detrimental to the treatment. Questions were gently introduced accompanied by enjoyable exchanges. At the same time the audience was taught what needed to be done with the patient while the supervisees were allowed to absorb information at their own pace. For example, a student who expressed concern that a patient was leaving treatment while she was writing a paper about him was asked, “Could the same questions be answered using another patient?” No criticism was offered, but this did not satisfy the supervisee, and Spotnitz experienced the strength of her wish that the patient would stay to help her. Experiencing the strength of this wish, Spotnitz turned his attention to the audience. He learned that the patient was in the audience. The therapist had not been able to interest him in returning to treatment, but she had gotten him to agree to attend the discussion of her problem to see if he could be convinced by Spotnitz to come back. Spotnitz obviously

wasn't doing this job for her. When he turned to the audience, he asked, “If we continue to discuss this, will the patient have a heart attack?” Addressing the audience, Spotnitz added that to protect himself, the patient should leave if he felt that he was in danger. This was a kind of elegant presentation of the modern analytic view of how to be with a student or patient without damaging the ego and at the same time help the patient/student to take one next step.

The interesting aftermath of that supervisory session was that the

patient returned for a session in which he informed the therapist that he did not want to help her. She used another patient to write about.

Although I was trained early by more classical Freudian analysts than modern and underwent a control analysis with Theodor Reik, I did have a modern analysis with an analyst who was first trained classically and who then later was influenced to develop a broader range of analytic thinking. What I learned was that Hyman Spotnitz and Theodor Reik could go anywhere the patient wanted him to take them. They are both brave men and my supervisors were brave women who gave those they trained the courage to take chances.

I try to work in the technical approach developed by Spotnitz because I have found that pointing out correct behavior to a patient or explaining to him why he behaves as he does-in fact any cognitive approach-causes the patient to feel attacked and does not strengthen the patient's ego or bring him out of a regression. More useful has been the approach of allowing feelings to come to full strength, and based on these feelings understand what is being repeated by the patient. I understand what is being experienced by the patient only if I experience the same feelings. It's beneficial to experience what the parents and others felt with the patient, but the real cure of narcissism lies in my ability to feel what the patient feels. In the beginning when the patient comes into my office, I relax and let the patient wash over me so I can discover how the patient hides his feelings, attacks himself, or projects. Differences in these basic patterns form the basis for a diagnosis and diagnosis is an important aspect of our work, but with a difference. Classifying someone a schizophrenic or a paranoid isn't crucial. What is crucial is the way a patient processes stimulation, here and now, in the moment. We distinguish between the patient who is using severe defenses such as withdrawal, psychotic projection or denial of internal stimulation through mental confusion, from the patient using those defenses that show a separate object field of the mind is operating at the time. The former state tells us that the patient is in danger from any overstimulation in the analytic office and *cannot* be related to in the same way as he can later when he is able to use less severe defenses. Diagnosis changes. I arrived at the diagnosis for the session by a study of the patient's verbal patterns of exchange. That is, if he conveys his meaning through indirect communications such as action or symbol, I am alerted to the fact that he is having difficulty processing feelings and stimulation.

A long time ago a patient was brought to my office by his wife because he was crazy, she announced, and during the first session he

sat silently for the entire hour. I asked him a few questions, mainly about his comfort and whether there was anything he wanted to say. Was there anything he wished to talk about? Should I say anything? But he said nothing. The patient sat staring at the far corner ceiling. At the end of the hour he informed me that, “I have a treasure buried in New England and when I am able to dig it up I would like to share it with you.” No other words were exchanged. His statement sounds like nonsense, but I had the feeling he was communicating with me. Beyond the fact that he would like to be able to tell me what is buried within him, I wondered what it meant that the treasure was buried in New England. My roots are in New England. Was he telling me he knew something about me? There was nothing cognitive about his words or his behavior during the session, but I knew that he had lots of important information he would like to share with me and that it was blocked. The analyst can be responsive to instinct, to impulse, and to emotion. Experiences can be converted from instinctual levels and from impulsive levels to emotional levels through a proper feeling experience with the analyst. Unfortunately for this case, the wife called to say she had decided to commit him and I felt sorry that she didn't want to work with his indirect communication and that I wasn't going to have the opportunity to do so.

Transference/Countertransference States

In “Drive theory in diagnosis and treatment” **(1981)**, I described the process modern analysts use when

working with preverbal functioning. I do not expect to understand the patient through language alone since he is functioning at a preverbal level. I know where he is by what I am contaged with: my visual and auditory experiences, my fantasies and, most important, my feeling states. When I am with a patient and feel alone, I wonder if the patient is driving me away because he fears the interaction, or whether he himself feels alone in a vast universe. If he speaks in a monotone, makes no attempt to establish contact and appears to be a person who cannot make much emotional or physical contact and I feel alone, he has withdrawn from stimulation and detached himself from internal stimulation in order to maintain his equilibrium. If he is able to describe his state, speak of a gray empty world, of profound emptiness or describe a deathscape, though he is stuck in isolation, there is some awareness of the world and a hope that he can be saved by the therapy. In either case, I ask him some questions to determine

the amount of contact he wants from me. Mostly I ask him non-ego-directed questions or make simple statements, both in a very limited quantity. If in response he describes his feeling state, I believe he wants to communicate and is motivated to attempt a tentative contact. I do not impose any irrelevant ideas or feelings on him. Through sparse questioning and mostly listening I learn more and more about the purpose of his defense. He tells me how he creates the environment in which he feels safe, how he avoids what is threatening, how he avoids feeling pressured, and eventually why he needs to stay out of contact. Thus far, my own feelings have been used only to get clues to his experience.

A second personality style that I have observed while doing treatment is the patient who is overtly terrified of the analyst and is experienced by the analyst as being equally dangerous, or who causes the analyst to feel that she is dangerous to the patient. With this patient it is possible that the analyst will feel suicidal, be enraged, or fear being discarded. The analyst may feel she has no control over herself, that she may run out of the room, throw the patient out, maybe even kill him. The analysis of a negative presence in the room and the impulses it stirs up in both have been the most difficult scenario for most analysts.

I've seen another kind of patient who enters a blissful symbiosis with me. I am a comfortable presence; the patient is neither alone nor frightened. This patient is not asking for interventions but just wants to repeat a connectedness to his positive feelings. The patient has successfully created the image of a friendly presence in his mind and it brings with it a sense of well-being. I've found that it is difficult for the patient to maintain this state if the analyst is too full of herself or makes intrusive statements. If this positive state appears in the beginning of the analysis, then I make no effort to question this state, to elicit feelings, or to bring out the patient's negative feelings until the patient reveals a willingness to move on.

Another category of patient, the depressive, frequently projects an omnipotent presence, but needs an outlet for negative impressions, so protects the analyst by attacking himself. The patient suffers from a half-empty cup and wishes revenge, but fearing these wishes, hates himself. I look at it theoretically as: object-self separation has not been sufficient to safely allow hatred to emerge since over-valuated object impressions are still a part of the self. The techniques developed by Spotnitz have proven most effective with depressives. If a patient feels he is worthless, I feel he is far worse than he can imagine. (I, too, am beneath contempt, but this is verbalized later)

These feelings form the basis for powerful emotional communications that can resolve the resistance of self-attack. It is difficult to believe that if we tell a person he is no good, the patient will feel understood. I told a patient who was planning to read a paper at a conference that she should tear it up. She didn't know how to write a paper and was too stupid to write a paper anyhow. (After her insistence that I must tell her what to say because she is so stupid.) Following this intervention she pulled the paper out of my hands, saying she was going to tear it up. Then she thought she should die. She wanted to leave and never come back. Finally she elaborated the ten or fifteen ways I had proved my inadequacy over the past twelve years, and she did an excellent job. She thought of some that I hadn't even thought of. Apparently this cheered her up because I heard later that she read a marvelous paper. People said they were spellbound. I have my own ideas about what works in this field, what makes sense, but she had prepared a fine paper that she did not have confidence in, and it included many ideas that had evolved from her own experience.

I've experienced other patients who are terrified of intimacy and become enraged with the analyst when longings arise. They behave sadistically, and fantasies of mutual aggression appear that interfere with constructive teamwork. They want to be back in the uterus but their fear of being swallowed up interferes. They

are tortured or want to torture the mother. The feeling state: mutual aggression. With blissful patients, we feel bliss together; with terrified patients, we feel endangered or dangerous; with patients who are alone, we feel alone. When a patient has aggressive thoughts and wants to protect me, I might ask him, “Why am I not doing a better job?” He, the patient, is doing fine. If the patient makes me wonder what I am doing with this worthless person, agreeing that “You are worthless” resolves a different ego problem. I ask a lot of questions if I have been feeling helpless for a while and I connect it to the patient. I ask, “Do you feel helpless? Do you want me to feel helpless?” I want to know if I am experiencing the patient's feelings. I find out if the patient wants me to feel what I am feeling because if I have the right feeling with the patient, the patient gets better. Some patients make me feel like getting rid of them, and if they do, I try to find out if they want to be gotten rid of. In all these conditions that I have described, it is plain to see the struggle with wishes and impulses, the inadequate opportunities for discharge, the rage and the creation of an object world based on externalized feeling states. I have observed patients in the process of externalizing parts of the self as a way of relieving

internal tension states. (You don't want me.) And I have observed patients as they create a fantasy of the external would out of the impulses and wishes they deny within themselves. I recognize that the circuits are closed, going round the same track, unable to experience anything new. I know what I cannot do. I cannot break in with thoughts. They have no place. I remain outside, reflective. In all these conditions, how the patient feels, and how he perceives me and the world to be, is what counts. If I try to convey reality, the patient is rejected. The greater part of the analyst's role during this period of treatment is as receptor, not explicator. When I can experience for myself the meaning of what is going on and shape an emotional communication, it has great power.

All of the above transference/countertransference manifestations reflect a regression to the stage of ego formation before language developed. All patients in long-term treatment will work at this level of nuclear conflicts-each feeling state and object perception represents a stage in normal development. They must be lived through, verbalized and not explained away by the analyst. People have asked me why I do not help the patient to understand why he does what he does and my answer is that he is functioning as an infant. He cannot use information any more than Freud believed a hungry man needs a menu card in a time of famine.

My job, as I see it, is to take a patient, who, when I meet him, can only demonstrate in action or avoid through psychotic defenses what he cannot verbalize directly, and create with him and within myself a language for the preverbal feelings. In helping him to learn to talk, I expect to uncover the fantasies that formed the structure of the patient's ego as it was constructed in the pre-object state from pieces of the self, wishes, impulses, primitive defenses, and impressions of the surroundings. Each patient takes me to his own special version of entering the world. In sessions I feel how and when the patient creates a psychotic defense to cope with impulsivity. To help him, while regressed, to convert into words his blurred images, fantasies and feelings, including confusion of self and others, is the apalyst's task. I have learned that the analyst's communications should not introduce new or alien concepts to the patient. Freud learned this through trial and error. In the case of Dora he presented his ideas to her. They were brilliant, but he lost the patient. He learned about transference through this case and that one only talks in the language of the patient. The analyst's words should be ego-syntonic, and the quantity of communication from the analyst to the patient dictated

by the patient's demand for feeding. This much has been confirmed by the experience and writings of modern analysts.

So long as the analyst does not attempt to educate the patient, the patient is going to feel comfortable enough to develop a narcissistic transference relationship. The analyst will be able to work successfully to the extent that he is willing to follow the patient's lead, not attempting to introduce the patient to a better view of reality-the analyst's view-and not attempting to resolve a patient's difficulties outside the transference relationship. Although it is true that language is the key to a deeper understanding of the patient's regressed experiences, my mind creates a scenario for each patient based on what I know of his history-abandonment, rape, incest, the facts of his life-and I think of interpretations explaining how he repeats that history, but if I make those interpretations to the patient, the regression and the repetition are not affected. Somewhere buried in the events are responses which are not verbalized by the patient and require that I experience what he experiences in the transference. Emotionally experiencing being where the patient is, even when he is in a chaotic or

negatively destructive state, teaches the analyst what the patient needs in the analytic relationship. Patients need to feel hated and to hate. They need to know that what they feel can be felt by others. Often they fear the analyst's loving kindness more than a good charge of the analyst's hate appropriately applied. They need to know the analyst can feel fear. I remember how important it was for me to go to the Selma March in Alabama in 1965, not because I could not appreciate that discrimination is wrong, but because I had to be discriminated against and frightened as I participated in the events there to even begin to fathom living with fear every day of one's life. Having been there emotionally helped me. Patients ask that the analyst go there to their special place so that they can feel understood.

The question to be asked is how finally, if not by interpretation, can be analyst introduce his experience with the patient. If the analyst resonates with the patient's feelings, nothing is required. The patient feels it. They are in tune. It is being in tune that leads an infant to constructive rather than destructive use of aggression. Patients improve when they experience this with the analyst.

The Case of Don

I rely on the patient to take me to the moment of truth when I may betray him, fail to understand him, fail to be a part of him. I had seen Don for two years when he offered me the opportunity.

We recently had a tumultuous session in which he said, “You want to get rid of me; you are going to get rid of me,” over and over. This followed a period in which he described his feelings for himself. Over a two-year period that I had been studying him, he had talked about how periodically he would lose heterosexual feelings and how he had been abandoned at birth. Age two was important developmentally in his life in that although he had been abandoned by his parents at birth, the event was not real to him until the age of two.

As you know, the baby in the first weeks of life is in an unreal state-experiencing but unintegrated. When he reaches the age of two he is in touch with the object world. This is a gradual process, but roughly that's what happens. When he was two he learned that he had been abandoned, literally, and the woman who cared for him (neglected him) was not his mother. I had lots of ideas during this time. The man was abandoned. He will get me to abandon him, but this did not feel like the earliest conflict. I had asked him why he hadn't found his mother. Why hadn't he learned all there was to know about his mother? Later I said, “Just go everywhere with a women.”

This intervention had a terrible effect on him and brought our relationship to a head. When a relationship comes to a head, when a patient reveals his conflict, the analyst has the opportunity to fail him or make an intervention that can be disastrous or resonate with him. I had said back to him the words he kept repeating, “I have to be with a woman.” He believed he was supposed to be hetero-sexual. But he lost feelings for a woman and used his fear of potential abandonment as a defense against relations. Being in touch with object hatred is very dangerous for him. During the first few years of analysis this man had always felt unreal to me; was there someone in the room? This sense of unreality did not fit what I knew of him consciously. True, he was born in an unreal world (that's how babies are), then abandoned; later he discovered a real world and the story of his original abandonment. When he reverts to preverbal life in sessions, it feels unreal. In fact most of the time he can keep it out of his thoughts. I could cling to the abandonment as a fact, and when we speak of the repetition compulsion I had all kinds of thoughts about how he repeats abandonment, but why the unreality? He regresses from the relationship with an adoptive mother to a period that is shadowy. In the transference it is only the presence of the other that is desirable. In the unreal period, he wanted daily sessions and he wanted to be with me all the time. He is afraid I may tire of him and get rid of him. It becomes clear that this is a duplication of the

earlier mother and the unreality in their relationship. The adoptive mother had abandoned him psychologically. He lives in fear that I will do as she did. His regression to a shadowy presence is his way of getting more of the time he needed with his mother to become real. He improves his life and behavior in every way he can with the expenditure of great quantities of emotional energy. Along with apprehension a warm atmosphere exists in the room when he regresses. All contacts stimulate great floods of feeling, so stabilizing the contacts was important and very difficult. The emotions wore him out-he had powerful anxiety states and fears.

I enjoy being with him. But much of the time, I'm not sure of any feeling; I'm on quicksand knowing the ground could shift at any moment. He cannot hold onto the image of those moments with the original presence.

He has spoken of suicide. He speaks of sexuality. I feel he feels it is his duty to be interested in me, to like me, and to feel sexual with me, but why? In a group he joined to be with me more often, he was afraid of women in general and could express anger and betrayal toward one of the group members; he was flirtatious then distancing. Nothing is clear when we are on this track. The conscious track we travel is: *My mother/adoptive mother* [confusion] *abandoned me. I am alone. You will abandon me. I want to want a woman*. When I said take a woman everywhere you go, in an emotionally moving group session where members complained that I said such a thing, he insisted that I was expressing his feelings and that the group members were failing to grasp it.

He spent a very difficult weekend and did not come to his next session. When I called him he said, “I didn't come because you told me not to go anywhere without a woman.” The anger was there. He could hate me for telling him to be with a woman. I strongly expressed the idea that this was a serious breach of our agreement. He arrived full of rage, telling me it's too difficult. “Are you going to throw me out because I cannot do this?” We are both getting closer to knowing that what he can't do is be with me, be with a woman. I continued to speak with feelings, saying that there is no way I can do analysis if the person cannot call me when it is too difficult, cancel appointments, not break them, and ask that I stop if it's too humiliating. He continues on his track: “You are going to get rid of me.”

This was the moment of truth between us-he would rather be abandoned than be angry with me. He would rather leave than be in touch with the reality of those first two years. When his anxiety had peaked about being thrown out, and it certainly sounded like

an invitation, I said that plenty of people come to my office who don't want to be analyzed. Some just want to hang out with me. That certainly fit the way he said he had been feeling about me, but now he changed his mind. He wants to be analyzed. I told him no matter what feelings are aroused, there can be no analysis unless he agrees to come and tell me when he cannot accept what I say. He noticeably relaxed when the realized I was talking about a structure for himm to be with me. And he communicated new information. Over the weekend he had gotten in touch with the basis of his suicidal wishes. Periodically he loses heterosexual feeling and wants to be alone, cocooned in a fetal position. Not wanting a woman, having negative feelings about me, losing his sexual feelings makes him want to die. The idea of being told to be with a woman, which is the command he gives to himself, when expressed by me aroused depths of rage. At the end of the session, feeling safer, he asked, “Do I have to like my mother?”

Weeks later he informed me that he now likes the way his original mother looks. He had obtained a photo of her and at first said, “She looks like a lesbian.” In the past he had described the closeness between his adoptive mother and her sisters whom he did not like. My own impulsive fantasies place him with his original mother. Don invited me to abandon him as she did, thus attempting to repeat one aspect of his past. He does not succeed in arousing a strong desire in me to get rid of him so this feels unreal. If he must love and want me, yet cannot, he must pretend and hide his feelings. Then my words, “want a woman” reestablish the connection between his suicidal thoughts and the waxing and waning of the feelings of wanting someone. Because of the intensity of his rage when he remembers the reality of his parents' abandonment and the unavailability of his adoptive mother, he regresses so that reality does not exist. If he stays preverbal we can play at love, but it is unreal because he must block the real objects and so the tension remains. Once when he insisted on the distinction between women like his mother who would abandon a child and the ideal mother, I told him all women are whores, and he said, “I hate you for that.”

How can the analyst maintain a mature ego while moving back and forth between the predesertion paradise, the abandonment, and life with adoptive parents? **Kernberg (1975)** and others have spoken of the importance of the structure of analysis if we are to enter the world of primitive fears and longings. He has spoken of the significance of maintaining the analytic rules of a fixed time, a fixed place and a fixed fee, with activities limited mostly to talking because it

not only conveys to the patient that there is an external structure, but it reminds the therapist that he too is limited by that structure. **Searles (1965)** has spoken of his journeys into psychosis and the longings aroused within him as well as the tensions and fears. He has lived intimately at Chestnut Hill Lodge with the most severe pathologies and has allowed himself to experience them within himself. He has helped us understand how much emotion can be tolerated without destructive action. When I read these men or Kohut, Winnicott, or Melanie

Klein, I am impressed by the similarities of their understanding of the journey, but I observe how differently each draws conclusions about what behavior on the part of the analyst will be most useful in the treatment. Kernberg seems to appreciate the relationship between drives and object relations and so does Searles, but all continue to interpret to patients. I know I want to interpret each time the patient arouses too much feeling in me. Often these feelings are too threatening to our defense system and therefore cannot be responded to with equanimity. We can only try. I try to teach my students that all fantasy, impressions, wishes, and fears are normal. What is abnormal is repetitive stereotyped thinking, feeling, believing, and acting.

It is to the repetition that the analyst addresses himself in his analysis of countertransference as well as transference. In analyzing patients with object transferences some feel that we need not resonate so completely as we do with the patient in a narcissistic transference. We've seen how we learn about early object patterns through having the feelings of parents and knowing what feelings the patient was subjected to in early childhood. All our patients move back and forth between preverbal and post-verbal experience, between reality and fantasy impressions.

The Case of Ann

A very pleasant young woman reports positive feelings in treatment, but resists by asking me to explain everything to her. I responded when she told me two dreams, asking her what they meant and why she wanted me to tell her? She said she felt she bored me. She wants me to like her. She tells me that she enjoyed the fact that two other analysts liked her, but they were not important to her. I am. “You're the one I'd like to know how to please,” she said. I said things that indicated I didn't have to be pleased and that frustrated

her. She said she had been more successful with her mother. She described a terrible childhood in which she listened to all her mother's complaints. I found out on further investigation that she did not feel she had been successful with her mother. She never did make her mother happy. The treatment was a letdown but she didn't know any other way to be with someone. She is burdened but can't find a way out. A great deal of reflection partially resolved her passivity, but her next stance was to demand that I should keep her alive. She said she had felt that she must keep her first analyst alive as well as her mother; now she would like me to cheer her up and interest her in life.

I asked her why I should want to keep her alive and why I should do it, and through these questions, learned that she would stay paralyzed unless I showed her I loved her. She tells me how she tricks me. She says she is unhappy in the room right now, lonely, and wants me to be with her, but she anticipates disappointment. Her trick is to get me to answer a question; then she doesn't feel alone. She repeats that she “expects to be disappointed,” but explains that she doesn't actually feel the feelings. She says, “I don't say to myself, oh my, I am lonely. I wish you would explain me to myself.” She says, “What actually happens is I get anxious and feel I don't understand anything.” (She regresses) She tells me there's so much unhappiness, yet she has nothing to be depressed about. It makes her sad that she cannot enjoy life. She tells me she wants to keep me alive, and I say that I thought she wanted me to keep her alive. “It's both,” she says.

It goes back and forth. Group members insist that I should tell her I love her, or at the very least, that I want her to live. Through this process she brings more feeling into her reports of her resentment that she had spent her entire life trying to bring her mother out of depression, cheer her up, get her interested in living. Now she's asking me to do what she did. Then she went to a depressed analyst whom she felt she had to entertain. When she got to me she had decided to give it all up. Enough time had been spent in childhood trying to arouse her mother's interest in life. She wasn't very good at it. She was sure that neither her mother nor her analyst had a really good time with her. She could never help her mother enjoy life with her then. When she failed, she just got angry and went somewhere else in her mind. Not giving her the gratification of her wish to be told she is cared for led to progressive communication.

This woman came to me in a state of resignation, with a life of accomplishments, a family and a career, but no good feelings about

herself. When she longs for a relationship, she feels she doesn't understand anything, is confused and lonely, and believes she can't get anything except by tricking me into giving her a crumb. I, for my part, have done

nothing to indicate to her that she is any better than she thinks she is, and I have questioned why I should want her to live, if she doesn't want that enough to do it for herself. This reflective behavior has whittled away at her apathy and led first to more direct statements of what she wants and more direct statements of how angry she has been behind the passivity. Alternating with this are communications which convey symbolically that she can take pleasure in herself and her life. This behavior on my part is responsive to her need for communications she had never received at the time she first needed to be encouraged to live. When the former precedes the latter, anaclitic responses do not prematurely cut off the reliving process.

Summary

When narcissism is present I find that I may experience disturbing thoughts and feelings, sometimes resonating with the patient's experience, sometimes experiencing his defenses. Until the patient's perceptions have been totally verbalized, the only goal I see is to help him to talk. The meaning of the patient's perceptions remains unclear during the preverbal period; it is only our feelings that give us any clues. If we want to help the patient succeed in the world before he has verbalized his psychotic perceptions, he feels we don't like him or we don't understand him. The concept of a narcissistic transference means just that, two peas in a pod.

The role of emotional communication during the unfolding of the narcissistic transference is to use the emotional knowledge of what the patient longs for to engage in emotionally relevant communications. The first result of this is that the patient sees the analyst as like himself. If the patient remains dead, I have no work to do except be there. The person I become to the patient will be the parts of himself that he hides from; the patient will tell me how terrible I am, cold or demanding, needy or crazy. Emotional education is that process through which the patient is allowed to feel safe to take back the parts of himself that he has rejected, and he can do this when verbalization has led to a feeling that he can know his impulses without damaging himself. When he feels understood, aggression is converted to constructive channels.

Questions and exploration play a major role in every analysis. The analyst's feelings lead to specific questions that the analyst will want to ask. If a patient is experienced by me as dangerous I want to find out what he wants to do to me, what he wants me to do to myself, what he hopes fate has in store for me, and if he wants the same for himself. If I feel a patient is dangerous and I raise these questions, I will find out if the patient is in touch with these feelings within himself. If he is not, and I am correctly experiencing his unconscious feeling states/wishes, then I am in danger, and so is the patient, if we do not convert these feelings into words and thoughts. When we are in agreement that the patient wishes me ill, I then explore why. How will it help him if I am beaten, tortured, or killed, and through these questions I learn whether he wants revenge, and for what, or whether he wants me to be frightened, as he is, and therefore, like him. What the patient is reliving and what I am feeling cannot be converted into reconstructions of the past while it is happening in the transference. As Winnicott (1953) and others have pointed out, in severe regressions the patient is *living the past, not remembering it or living a parallel to it*. This is the only moment in time. Feelings are being experienced in the here and now, both those of the patient and those of the analyst. Every emotion repetitively experienced in the treatment of a patient is brought to language by the analyst. It is through creating a language for feelings that the patient is cured.

Patients come to us hoping to escape the repetition. They don't want to murder us, live with us, be tortured by relationships, get rid of us, or be gotten rid of by us, but these feelings are the daily menu of psychoanalytic treatment. Surely they require that we feel a lot of bad, hard feelings. Understanding the repetition in the transference will eventually lead to understanding the patient's perception of the past. It need not be reconstructed by me. My patients eventually create, and talk about, their own histories when they need to put the past and the present together in order to move out of the transference. You will note that Ann, the patient just discussed, provided her own interpretations in respites between actual reliving of earlier emotions, and Don eventually made the connection between the real abandonment which was unreal emotionally and the unavailable adoptive mother whose abandonment was very real.

I want to remain flexible enough to move back and forth, session by session, from the unreality of the beginnings of life to the realities of early life in each patient's experience and not lose my bearings in the uncharted waters of the psychic depths. I hope my patients can learn to forgive me my limitations when the journey is complete.

A patient moving from projection to recognition that aspects of the analyst are different from himself, and to self-acceptance, begins slowly. One such patient was tormented by any contact I had with other patients. She spent her time telling me what was wrong with these people. In fact, it disturbed her greatly that I could accept, even be willing to talk to, such sleazes. A new note began to appear when she said, “You really like a lot of different kinds of people, don't you?” And she seemed positively impressed. “I can't seem to do that,” she added. Before long she was asking how she could learn to be more accepting, appreciating those whom, until now, she had been so ready to dismiss as beneath interest, time, or effort. Her competitiveness remains a major character trait. There is growth in the mellowing, in her acceptance of a wider range of people. Vicious rages and envious vituperative attacks on those I am suspected of favoring have been replaced by curiosity. There is motivation to look at others and to consider valuing them as people whom it could be a pleasure to get to know.

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