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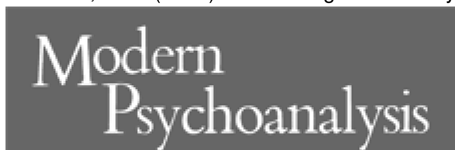

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Resonating with the Psychotic Patient*

Phyllis W. Meadow, Ph.D.

The method developed by Freud for working with neurotic conditions is fairly straightforward. In a neutral setting, the analyst allows conflicts to be transferred into the clinical relationship. The disappointments and dissatisfactions of the patient's life become a part of that relationship and are put into language. Interpretations are offered to explain how the present is connected with the past, and treatment is concluded when enough has been said so that analyst and patient can part company with predominately positive feelings and the patient has improved his ability to communicate. However, many patients did not respond well to this early psychoanalytic approach.

Since Freud's dismissal of narcissism as untreatable and his portrait of the personality as entrenched "behind the stone wall of narcissism," analysts have tried to breach that wall in order to make a connection with patients who are withdrawn from the world and detached from their feeling states. Current journal literature records these attempts to make contact with those who live in isolation. Conference titles such as—On Becoming the Patient—are a result of our earnest desire to comprehend how therapeutic influence can occur when regression is to the preobject, or self-object states.

Some of the material in this paper was first presented at the June 1990 conference, "On Becoming the Patient," held at Clark University, and sponsored by the Boston Center for Modern Psychoanalytic Studies (Brookline, MA.) and local community agencies in the Boston/Worcester, New York and New England areas.

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The Prementational Phase of Life

Working with psychotic and prepsychotic regressions we learned that early experiences cannot be changed and that patterns of response, or ways of perceiving events, cannot be modified through our words or even through our kindly deeds. The patient has retreated to an unreachable place. We learned that intervening to deal with real-life frustrations is usually not analytically helpful. We learned that severely disturbed patients are able to obliterate thoughts and feelings in order to protect the early impressions on which their egos were built. In response to our explanations the regressed patient may go blank, continue as though not addressed, or he may stop talking. The patient may respond positively or negatively depending on the rhythm and tone of the analyst's voice; he responds to the emotion in a statement and may read the intention more negatively than the neurotic; he frequently responds to gestures that accompany the analyst's language as if wary of danger in the relationship. Any attempts to persuade, control, influence or convince will meet with the wall of narcissism.

Giovacchini (1989) describes this phase as a prementational state and points out that the analyst cannot rely on an introjective process to establish a relationship with the patient. The patient appears to have shut down, with no mechanisms for internalizing experiences. The patient fights against letting the analyst in.

Analysts since **Winnicott (1954)** and **Spotnitz (1952)** have described how the analyst works with this preverbal regression/ fixation. Recognizing the fixation at a prethought, preaffect state, analysts (including Margaret Little, 1990, in her analysis of her own psychosis and treatment) have searched for a way into the psychic systems of these patients.

Winnicott (1950) concluded that the psychotic patient required that the analyst become the patient's case manager, that he handle the patient as a good-enough mother handles an infant in the undifferentiated state. In his practice this good-enough care included holding, feeding, comfort and protection against trauma. Modern analysts are concerned with the dangers of oversolicitious or supportive treatment of the infantile ego as it copes with inner tension states. They have recognized the necessity to control carefully the amount of stimulation the patient is subjected to during sessions.

A woman who entered treatment severely regressed helped me to understand the negative effects of the case management approach

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which utilizes positive feedback. She was enraged and had been brutalized in relationships. She did not want me to speak unless she requested it. Positive, negative or neutral communications were out. Any type of contact was overstimulating. She wanted to want to be with me and she guarded against my saying the wrong thing. She did not want to be disappointed, but whatever I said was overstimulating. After many years of analysis in which contact improved, she was able to tolerate more of my inadequacies, but her self-devaluation continued. She married a man who was terrified of being a disappointment. For several years they tried to develop a sexual relationship. He was awkward and afraid and she was disturbed by every disappointing gesture. Their sex life tapered off because neither could tolerate the rage and depression that inevitably followed their attempts. Disappointment and rage continue to dog her interpersonal life. What has changed is her tolerance for stimulation and an ability to lead a productive work life. I've asked myself many times what would allow her to balance her negative self-image with a realistic appreciation of her life. She feels loving and loved in analysis much of the time, but self-love has not replaced the deep self- hatred. Now she is more tolerant of feedback, but only after each working through of bottled-up negativity.

The Role of Aggression

Freud predicted (1938) that an understanding of psychosis would await the integration of a separate aggressive drive. Within ten years of Freud's death, some analysts had taken up Freud's challenge. Spotnitz, a neurologist and psychiatrist working with others (late forties, early fifties) in a research program at the Jewish Board of Guardians in New York, observed childhood and adolescent schizophrenics and discovered that the schizophrenic and preschizophrenic consistently manifested deviant patterns for discharging aggressive impulses. **Spotnitz (1986)** described the nuclear problem in schizophrenia as a "highly specific and ego-damaging pattern of self-protection against the discharge of aggressive impulses." He described the regression to the infantile period as an actual obliteration of the object field of the mind and a fragmentation of ego. In a regression to the undifferentiated phase of development, the earliest self-representations and object-representations overlap. He saw this regression to the formative states of ego development as the result of "a struggle between the explosive forces of the aggressive urges

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and the inhibiting role of the libidinal urges." Analysts discovered that in cases of schizophrenia, paranoia, depression, melancholia, autism or mania it is necessary to arouse a special interest in the therapist so that the patient can be influenced to be in emotional contact.

We now know that schizophrenic patients have not learned how to discharge rage, but instead bottle it up in order to protect the growing object impressions of the mind. In treatment, these patients struggle to blot out transference impressions because to want a relationship with the analyst recreates the need to protect the budding object field. These patients try to blot out feelings, impulses and longings for connectedness. It is necessary to resolve their resistances to feelings at a pace at which they can control their impulses. We have learned that decompensation results when aggression is not properly handled.

To know more about what can motivate the severely disturbed patient to form an attachment to the analyst becomes the first interest in our work with these patients. Analysts studying psychosis have come up with varying explanations of patients' reluctance to be aroused and their active avoidance of connectedness.

The patient's process of separation into a self and other becomes one in which destructive urges must first be perceived by the patient as coming from outside his own psyche. Studies of fetal growth and intrauterine life convince us that patients who are oblivious to others can be very dangerous. We experience fear when with a schizophrenic as though part of our minds is in touch with his bottled-up aggression. The fetus, the newborn, and the regressed patient have no idea that in pursuit of their needs they can damage themselves and others. In his physical development the fetus incorporates what he can use from the mother's body and grows at a rate that would rip her body apart if she did not protect herself by ejecting him. Biologically and instinctively the mother engages in processes that prevent her from being damaged. If she is out of touch, she may hold onto the fetus and wait for a doctor's intervention to take her baby from her. Neither can the analyst afford to lose touch

with the patients's potentianl for destructiveness.

Patients who are struggling with bottled-up destructive impulsivity may enter treatment in a negative narcissistic state. They feel endangered in the room and may regress stil further. (The earliest sense of self occurred when dangerous impulses could be externalized **(Klein, 1946)**.) The first task is to help the patient stay in the room as he separates himself from the bad and to assist him in this process of externalization. For this patient, the first phase of treatment

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focuses on how aggression is being processed. A distinction is made between stages when the patient responds with reflexive or impulsive patterns and those stages in which his patterns depend on the existence of some object awareness. In object-related phases, the analyst observes how the individual organizes impulses for contructive and destructive actions towards himself and others. The picture that emerges then is of deviant discharge patterns related to internalized unwholesome object experiences as they are projected onto the analyst. When we start a treatment with the knowledge that destructive patterns will dominate, we work to free constructive impulses from their function of protecting object impressions while simultaneously we work for rechanneling of destructive urges.

For the object-related patients, Searles and others have demonstrated their skill in getting in touch with introjected objects and in feeling the parents' feelings toward their patients as well as the patients' feelings toward their parents. **Searles (1965)** taught us how we “catch” the patient's introjected feelings, and more recently so have most analysts in the avant-garde of treating those preverbal disorders in which early object impressions have emerged.

We need now to understand the earlier prementational state in which introjective processes do not yet function. It is a state that predates the ability to take in impressions from the outside through the sensorium. We look at the experiences out of which the primitive self was born. In patients with a weak desire for life and/or a dominance of destructive impulsivity we witness how when they become aware of a presence in the room, terror of the other replaces the experience of internal destructive urges; this is an adaptive function for that phase. These are the patients who are to be born in the analytic room. The analyst learns that the patient moves between the absence of another presence, accompanied by feelings of aloneness or emptiness, to states in which a blurred image of the analyst is present.

What is needed in this regression is an analyst who can live through the emergence of the patient's self- and object-field.

Many problems exist in this stage of analysis. We ask, how can the analyst be present without disturbing the unfolding self? Will the difficulties of the treatment situation, which entails so much frustration, be too dystonic? We know from verbal patients that the very act of paying for treatment is a narcissistic injury. For this reason, it is desirable in the early months with the analyst that the patient not feel that anything is happening. Goldberg describes the analytic environment **(1991)** “like taking a bath at body temperature, feeling neither heat nor cold.” The patient may need the emotional

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in-tuneness that the mother offers. Patients in long-term treatment say things like, “You didn't want me when I was born,” or, as one woman said to me, “You were afraid of me when I was infantile. You felt inadequate as my mother.”

Research on Relatedness in the Early Developmental Stages

Despite the lack of scientific proof, those in the vanguard of analytic treatment of narcissism are using concepts such as synchronicity, resonance, and becoming the patient, to discover what has a curative effect on the preverbal patient.

A research project by **Piontelli (1989)**, a study of twins before and after birth, supports our clinical observation that constructive and destructive forces are in place and operating dynamically at birth. With the aid of ultrasound the twins were observed in utero and using Bick's method of infant observation they continued to be observed for three years. Her findings suggested “a cautious approach to the question of maternal influences on the fetus, in terms of fantasy or emotional life, although maternal influence after birth can be extremely important in thwarting or fostering innate individual tendencies.” She found it possible to observe clear individual

temperamental differences from the early stages of fetal growth (18 weeks). Each of the twins observed seemed to establish a "characteristic pattern of behavior that continued in the same direction after birth." What were these characteristics? Individual differences found their expression in various somatic manifestations such as the choice of postures, repetition of certain activities, and quantity and quality of body movement. Some twins showed no reaction at all even to the strongest kicks or punches. Some seemed to perceive contact and actively react by withdrawing and turning away from it. Others responded to contact. Still others not only responded to contact but seemed to search it out actively. For instance, responses could be gentle, affectionate, cheek-to-cheek stroking or they could be violent, with each contact ending in a fight. Contact in some twins led to instantaneous countercontact followed by immediate withdrawal as if the twin during the touching had been struck by something akin to an electric shock. These clinically observed individual and couple patterns continued to be seen in later life.

These findings lead us to the conclusion that character and temperament

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may predate any of the usual contacts with the mother that have been thought to be so basic. Piontelli found some twins who gave the impression of life-seeking, long before birth; others seemed to refuse psychological birth, long after their physical birth. One set of twins, Celia and Mark, illustrate these differences. Celia, in utero, moved her hands, legs, and head, rubbed her feet, yawned, bent her legs, stretched them, joined her hands, put her fingers in her mouth and, in general, seemed lively and interested in trying different movements, positions and sensations. She seemed interested in life and her surroundings. On the other hand, Mark tried to bury his head in the placenta. Stimulation from his twin led him to turn away, retreating to a distance. Even the most gentle touching on her part led to violent kicks. In later stages Mark continued to shield his face with his hands. With less movement possible as they grew, Celia added new dimensions to her repertoire, movements of muscles of the face: yawning, smiling, sucking, frowning. Mark remained impassive. After birth Mark refused the nipple and the mother forced it into his mouth. His eyes remained half-closed. The stimulation of sound, light and movement resulted in a pained expression and the same shielding of his face. Piontelli concluded that some babies welcome life, some dread it. The idea that in utero the fetus already demonstrates a dominance of the wish to live or the wish to turn away from life presents us with a clinical quandary. Our earlier understanding of countertransference as having feelings of the patient's introjects may not always apply. The role of the analyst's induced feeling states now can be used to distinguish between object conflicts and those situations in which life-rejecting patterns are actively conflicting with weaker life-enhancing forces. When the latter presents itself we ask, "What is cure in a person where the desire for connectedness is so weak?" "Can this be treated as a resistance that is psychologically reversible?" "Can the patient be joined in his lack of interest in life or helped to change such an early motivational base?"

I think of a patient whose constant refrain is, "There is no place for me in the world." He finds all the people in his life difficult. He describes his job as filled with pressures, providing no joy. His homelife is much the same. His wife and children do not understand him. They are selfish. He does not feel physically comfortable in the space of the home which his wife has furnished with repeated requests to him about where he would like what. Does he want a desk? In which room? He dismisses all this talk as a bother and takes no steps to improve the space to suit his needs. At work he complains no one

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helps him, but when people offer to help he feels they are in the way. I found that joining him in his dissatisfactions had no effect on his chronic unhappiness. When I realized that nothing made him happy, that this was his style, I concentrated on what he could enjoy about the sessions and what prevented him from enjoying our relationship, and, equally important, what I needed to do to enjoy my time with him. I wanted to know the extent to which resolving my resistance to enjoying him could affect his enjoyment of life (a mother who did not want him). In the case of Mark which Piontelli wrote about, we saw that Mark's mother preferred the passive, detached child to Celia, who was too vivacious for her mother. These twins were followed for eighteen months, not long enough to know the degree to which they would be affected by their mother's response to them so we can only speculate on how a later shift in the mother's wishes would affect her Mark.

The first phase of my treatment of my patient, Mark, had focused on the way he processed aggression, both aggression from the undifferentiated state of early infancy and that patterned later in object relations. When the patient was object-related it was possible to study how he organized impulses for constructive and destructive

actions directed toward himself and others. When this patient made it clear that nothing but failure would be tolerated, I learned how powerfully this arouses the desire to be rid of the patient, to give him interpretations and to experience the feelings in the sessions as intolerable. Understanding these feeling states and their source was the beginning of understanding the depths of this patient's rejection of life.

An important lesson I learned from Mark was that despite the power of his repetitions it was necessary that I join him there rather than interpret or try to change his mind by cheering him up. The ability to resonate with the patient's feeling states proved important to his treatment. At other stages, the ability to be asynchronous proved therapeutic. I discovered that patients need both distance and closeness. Patients cannot remain alone, nor can they be “in synch” always with the environment. They need instead the presence of an external self, a reflection or a twin, before they can entertain new perceptions other than those on which the ego was originally built.

A second research project, conducted by **Spotnitz (1977)**, helped me with this concept. Work in the neurosciences on synchronicity

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(1967[*]) had attracted the attention of Spotnitz. He was interested particularly in how certain psychic phenomena might be related to synchronous and asynchronous brain wave functions. The studies he reviewed yielded ample evidence that synchrony and asynchrony were more than plausible assumptions. The idea that in therapy a person might learn to be in rhythm with himself was appealing. A later paper **(1970)** by Yalom, reported in Spotnitz, suggested that cohesion between members in a therapy group might be an analog of the synchronicity of brain waves. With these ideas in mind, Spotnitz conducted a short-term group with eight members to determine whether there was a phenomenon of group cohesion and how it would be experienced by group members. Shortly before the dissolution of the group, Spotnitz asked group members to describe their reactions to the group experience. He found that the reactions of the members clearly testified to the development of group cohesion. One of the interesting assumptions based on his investigation was that just as interconnected neurons in the brain somehow stimulate one another to beat in the same rhythm, synchronous neuronal activity in one member of a group may stimulate similar activity in other members. He concluded that as new neuronic patterns are established in sessions and the memory of them persists, the earlier, psychologically constricting patterns may fall into disuse.

Becoming the Patient: The Narcissistic Union

Despite the difficulties, we have learned how to establish a transference with psychotic and borderline patients, a narcissistic transference. In some stages we experience the feeling states of the parent or caretaker. These early *object* transference stages allow us a greater latitude of responses to the patient.

In earlier regressions we experience the feeling states of the patient prior to the birth of ego and through the process of its formation. In still earlier regressions we may have to learn how to be in tune, or in rhythm, with the patient in the unformed psychic state. When the analyst learns to deal with the obstacles to this type of regression within herself, she moves towards “becoming the patient.” If a

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Findings bore out the potential of many thousands of neurons observed in EEG brain waves to fire in varying degrees of synchronicity. Further, it was found that synchronous rhythms correlated with high awareness and efficient behavior. These findings suggested to Spotnitz that individuals undergoing psychotherapy might lay down special patterns of synchronous functioning in the brain.

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patient, alone in utero, gets in rhythm with himself, maturation can occur. And so with the analyst. When the analyst experiences obstacles to this type of synchrony, she may resort to kindness or benevolent behavior with the patient. These maternal acts cannot free the patient. He is only reminded of his own worthlessness, or the kindness may be meaningless because he does not yet live in the world with a mother image. We have learned that analyst and patient have depths that must be reached before the patient can separate. When a patient presents preverbal material repetitively during an analysis, the analyst will have her own regression. Modern analysts were one of the first groups to put forward this idea of emotional contagion. The analyst, when contaged by buried destructive impulsivity, may feel the primitive rage that the patient cannot experience

because he closes down—both blocking off stimulation and removing himself from feelings and thoughts that would arouse him. This material surfaces under the power of the resonance that occurs between patient and analyst. The analyst may call upon the same defenses used by the patient, blocking perceptions, thoughts and feelings, functioning in the schizophrenic withdrawn state. When the analyst experiences her own destructive impulsivity, she will be aroused to get rid of the patient, to torture him with hurtful interpretations, and these urges may become very powerful. As the analyst struggles to understand her feeling states and their source, she begins the process of understanding the patient.

One of the difficulties in instructing a young therapist to work with these induced emotional states is that the therapist must first be trained in the method of systematic analysis of resistance. Knowing our feelings is not a license to be one's own self with a patient. The above feelings, if reported to the patient, could be dangerous for the treatment.

Narcissism in the Analyst: A Tool

When we work with psychotic or borderline patients we make many inferences from what we are feeling when with that particular patient. A supervisee reported that she was having difficulty being in the room with a pair of 13-year-old twins. She felt shut out by them. Even when they teased her, asking her to guess which one was which, she felt excluded. The twins spent much of the time in sessions fighting with each other, and she didn't see any reason for being there. When she asked what they would like to talk about, they said nothing.

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They didn't like school, they didn't like being with anyone, and they didn't want to come to therapy. It was their mother who forced them. The therapist was able to use her feelings, which reflected theirs, by asking if they would be willing to ask their mother to let them stop. They replied by describing their mother as intrusive, angry and demanding, always requiring them to submit to her will. This report reminded the therapist of her own initial desire to control the twins and get them to behave, which she had wisely not acted on. The therapist then asked if she should tell their mother to allow them to stop. They wondered why the therapist would be willing to do this, since she would lose money, but they got more interested in her. Finally, they concluded that their mother would never agree even if the therapist were to ask. This seemed to remove the therapist from the mother's camp. In the next session they seemed resolved to continue coming and the therapist had the feeling of being included in the discussion. Getting out of the role of the mother and into a new connection with them led to the next set of feelings—the twins hated being together as much as they hated being with others. The therapist is now waiting for her inclusion in the hated trio.

Symbiosis or oneness with a patient can be detrimental under certain circumstances. Another member of the same training group as the twins' therapist was experienced by me as overwhelming the patients she treated with her own needs. When the twins were discussed, Emma told us that her mother was a twin. The last thing she remembered her mother saying was, “Oh, Emma, what are you doing here? You're dead. I saw you in your coffin.” Emma seemed bitter as she told us that she never existed for her mother. No one existed for her mother but her mother's twin. She added bitterly, “She always wanted me dead.”[*] This woman always puzzled me. She had a capacity to enter symbiotic relations with patients and a strong desire to protect them from all others. Her patients did fine with her so long as the symbiosis was needed. She was enraged and frightened when encouraged to help patients live in the real world, to fend for themselves without her protective outreach, so that they could do what was in their best interest rather than try to read her mind and perform according to what she thought was correct for them. Many of this woman's interventions led her patients to confused states and, on occasion, actions destructive to their functioning

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The group's interest in twins led them to speculate about Emma's mother. The group members felt that the dying woman's message may have dated back to fetal or post-fetal times when she wanted her twin out of there, owing to her own need for aloneness.

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in the world. In the session in which she revealed that her mother was a twin, I had a vision of her as putting her arms around herself as she embraced her patients in the warmth of her protection. With this understanding of

the self-enveloping role of her work with patients, I felt I could help her to integrate these split-off parts. Her need for twinship leads her to symbiotic relations with patients. She is not ready to experience the patients' rage or separation.

When I felt oblivious to another patient whose parent was experienced as being totally oblivious to him, I believed I was having the parent's feelings. Earlier in the treatment I experienced the patient as oblivious to me. I was thrilled when he aroused me from my lethargy to say, "We've been goofing off. I think it's time we got to work," indicating we had had enough twinning isolation so could move on.

If I am impressed by the patient, I may assume the patient wants to be noticed. Hopeless or hopeful, I will want to recognize the feelings as his, tolerate them, not act on them, and thus provide the patient with a twin image. In my discussion of *Object relations in a drive theory model* **(1989)**, I talked about the analyst feeling the parent's feelings, even back to the in utero contact and noted that a patient will repeat feelings in the negative narcissistic transference that were part of his reaction to contacts with early mother impressions. But analysis does move between levels of maturation, sometimes returning to those states prior to awareness or the formation of ego.

Experiences in the earlier state are predominantely visual, tactile, auditory, having no thoughts or feelings to accompany the impressions—a dream state. Some patient experiences can only be remembered in the body. And these can only be relived in fantasy or action. I find myself moving between feeling states of joyous oneness, deadness, and impulsive or destructive urges. These feeling states reflect how the patient can connect with me, and they tell me the amount of stimulation he is seeking. Some patients appear joyous in the unity but anxious about being egoless. Through their behavior they tell me that their desire for life is strong, but that they were probably greeted at birth with caretakers who preferred they be quiet. (See Piontelli.) Those patients who were deprived of an emotional oneness of sufficient duration transfer this need to the analyst, experiencing an identification with her omnipotence. They may induce a desire for oneness in the analyst or they may induce the original introject's feeling state of not enjoying being with the baby. The first feeling can be used. The latter may be stored by the analyst for study and consideration of how it might be used later.

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Narcissism in the Patient

The schizophrenic will enter the analysis very cautiously, avoiding arousal, and may put the analyst into a lethargic state. He is defended against emotional connectedness and requires an analyst who does not overstimulate with her own presence, her own feelings and ideas. He also needs a treating partner who will help him to discharge aggression so that he can be freed of his need to protect himself from powerful transference urges. A psychotic transference can be established if the analyst joins the patient's perceptions, to provide a presence not unlike the patient's self.

Recently, the story of Harry, a pre-schizophrenic adolescent, was reported in a monograph **(Spotnitz, 1988)**. It described the use of a narcissistic transference to reconstruct a psychotic ego. Harry, like Narcissus, feared relationships, feeling that they would be destructive. After great difficulty, Harry finally arrived for an initial interview near the end of the allotted time. The first dialogue with his therapist went as follows: Harry wondered why he was there. The therapist responded by saying, "You don't have to come." Harry pushed on: what's the purpose anyhow, I don't need any help. I'm perfectly normal. And why would you want to help me anyway? The therapist said, "My job is to understand you." Harry replied, "Well then I can tell you everything in five minutes. I was born and I'm still living, so… why should I come again?" "You don't have to," the therapist reiterated. Harry thought this over and said "Well, I could come for one or two hours." "As you wish," the therapist said. "Next week?" Harry looked confused, was silent, then asked, "Why don't you persuade me to come," and the therapist repeated that it was up to him. Harry said that he couldn't say whether or not he would come, but will if he feels like it. He did not arrive for the next session, but his mother called several days later to say he wanted to come in. The therapist's nonintrusive technique led Harry to the conclusion that the therapist was not really a person, but more like a part of Harry, and he decided that perhaps they could spend some time together.

In this brief session, a lot was learned about Harry. His extreme avoidance behavior and tardiness demonstrated how fearful he was of establishing a relationship in which his negative and turbulent feelings would be disclosed. The act of coming revealed his need to be understood. The therapist used their time together to measure the rhythm, volume and tone of Harry's emotions and he modulated his

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expressions accordingly. Frequently this is done intuitively as the therapist is contaged with the manner and style of the patient. He learned through Harry's insistence that he was normal that Harry feared being seen as crazy.

The next few sessions revealed that Harry was afraid of his impulses. He thought he might be a homosexual. He would be found by his mother tightly wrapped in blankets like a cocoon as if to protect himself from the dangers of action. His fear of sexuality was expressed later when he wanted to be stimulated by touching forbidden parts of the therapist and to release his energy in the form of ejaculation.

Another patient, who did not become schizophrenic but psychopathic, discovered at seventeen that his mother was having sexual relations with his older brother. When he found her crying, she explained, “When your father died he made your brother promise he would take care of me.” “I'll take care of you,” said the younger boy. His mother told him he would regret it later, but she submitted. Their sexual contact continued for many years until this man decided his mother was no longer pretty enough; then he sought out other women. The therapist felt no negative feelings toward this patient. In fact she found him both stimulating and attractive. She had powerful urges to abandon treatment and have sexual contact with him. In other ways, she revealed that more than an identity with his mother, she had caught his need for instant gratification of any and all urges. The supervisor was impressed that the therapist contained her impulses and kept the patient coming, talking and paying regularly while all this was put into language with her supervisor and analyst. At the same time she became much more flexible in her responses to her own impulses outside of treatment. Eventually the therapist met a man and developed a satisfying life of her own. This patient left her when his interest in younger women took up more of his time. When last heard from he had not married, but was pleased that women found him so desirable. At work he was well liked. People said he was a pleasant fellow.

Both the above treatments demonstrate the therapists' identification with the character of the patient in the narcissistic transference-countertransference interaction. The primary goal in each of these treatments was to help the patient put the feared impulses (in the first case) and acted-on impulses (in the second case) into language. In Harry's case this would eventually lead to an abandonment of the defense of emotional withdrawal.

The analyst who joins the patient in his space, and does not ask

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him to accept the analyst's vision, makes the narcissistic attachment possible. If the analyst remains with the patient, the patient is not alone.*

Patients frequently come to us disturbed and agitated, coping with excesses of frustration or unable to cope with ordinary frustrations, and in the sessions regress to the omnipotent state of oneness. Both analyst and patient feel at least good and at times euphoric. The required oceanic state means that the analyst will not experience reality; it is a state in which ego functions have no immediate role and judgement and perceptual functions are temporarily suspended.

Education cannot be the goal in work with the prepsychotic ego. It is for this reason that I cannot see a role for interpretation. Giovacchini (1989) has noted that perhaps interpretation is not the most important intervention in these cases since there are, in the prementational period, no mechanisms for internalization. (Even the twin studies show only the strength of the drive to connect, not a capacity to internalize.)

The therapeutic task is very different if I am looking for what introjected objects or part-objects led to pathology than if I am dealing with a low drive to live and a dominance of destructive impulsivity. In either case I am contaged with the patient's preobject states.

We have learned that analyst and patient have depths that can be reached. As the patient presents preverbal material repetitively during an analysis, the analyst will have her own regression. Modern analysts were one of the first groups to put forward this idea of emotional contagion. The analyst, when contaged by buried destructive impulsivity, feels the primitive rage that the patient cannot experience because he has closed down, both blocking off stimulation and removing himself from feelings and thoughts that would arouse him. This material surfaces under the power of the resonance that occurs between patient and analyst. The analyst may call upon the same defenses used by the patient; she may block perceptions, thoughts and feelings to functioning in the schizophrenic withdrawn state. When the analyst experiences the destructive impulsivity, urges to take action may become very powerful. As the analyst struggles to understand her feeling states and their source, she begins the process of understanding the patient.

I mentioned in a faculty discussion that I thought perhaps this joining is easier for women. After all, women like the intimacy

of carrying a fetus for nine months and they usually feel at one with the nursing infant; however, the men disagreed with me, saying the only way a man is different from a woman is the y chromosome. All he has to do is give up reliance on it in his interactions with patients.

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The depth of the joint regression is a fuction of the time spent together, the length of treatment, and the conflicts that surface in disguised form during the treatment. I understand the patient when I can feel the same feelings he feels and can allow them to come to full strength, particularly his unfelt urges, impulses and blocked rage. A patient who, like a broken machine, continued to act hateful and to torture me with never ending complaints, said with rage, “You are very inconsiderate of me. What you did is despicable, with no thought for my feelings. I hate you,” and continued in this vein for the balance of the session. This repetitive communication returned and returned. Finally, I expressed how fed up I was with his repetitive interpretations of anything I say as an indication that I care nothing for him. I told him I was tired of his endless perception of me as hateful. His response was to cheer up and to think of very funny things to say. Over time I have learned that this behavior occurs when he has sexual feelings for me and that my response of anger is not useful in resolving this repetitive communication.

In reviewing cases in the literature, I found that most psychoanalysts believe that the patient can be helped to mature if he can be brought into the analyst's space rather than the analyst entering his. This has not been my experience. I have found that the patient who looks out of himself and sees me feels alone—if he looks out of himself and sees himself in the room, he is no longer alone. He can release his constructive energies from their defensive function. Part of freeing constructive energy is allowing the patient to arrive at his own constructions of what he and his environment are. Interpretations arrived at by the patient are more ego enhancing than those delivered to the patient by an analyst. At the moment an analyst delivers her perception, the patient experiences separation and the feeling that something is wrong with him. Distance exists between patient and analyst. Through remaining close to the patient's way of perceiving, we wait for the experience reported by Lindner (1948) when he joined his physicist patient in his flights of fantasy into outer space: when the patient was ready for change he said, “Look, this is only a fantasy, you know?”

Reconstructing the patient's past satisfies his need for structure, but does not lead to structural change in the patient.

If I make the sounds of a separate object with the patient who is still functioning as though in his mother's belly, he will defend himself against me. To enter the world is to enter the world of the patient's projections. First the patient must learn to say what those projections are. A patient who said to me, “You are angry with me

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for leaving you. You want me to return. You are going to punish me,” is beginning to form the first fantasies that lead to an external reality. This patient has difficulty being with me, but longs for union. He tends to externalize the longings, viewing them as mine, in order to reduce the internal tension. As he moves to awareness of these as his own wishes and fears, he becomes aware of fantasy. For the schizophrenic to have a fantasy is to mature.

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