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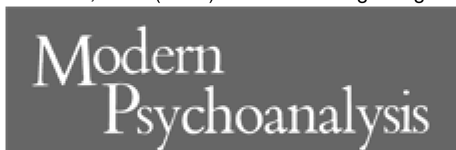

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Treatment Beginnings*

Phyllis W. Meadow, Ph.D.

The initial sessions with a psychoanalytic patient make evident the rationale for the particular style each analyst has of entering a relationship with a patient. For my part, when I begin an analysis, I pay attention to the simplest concerns. For example, the room should be pleasant, neither too warm nor too cool, neither too well-lit nor too dim. My style of dress is usually not extreme, nor does it attract too much of the patient's attention. I want to enter the session relaxed, that is, free enough of distractions so that I can be interested in what the patient wants to talk about. However, I don't want to be overly interested—I don't want to lean forward in my seat or hang on the person's every word. In the first session my primary interest is in why the patient is consulting me. To find out more about the problem I ask some variation on the question, “What brings you here?” It is not my intention to say much more in the early part of this session unless the patient addresses me directly with questions, or a question is necessary to make sense out of what my visitor is saying.

I find that when I act like this in the first session my visitor responds in his own style to my question “Why are you here?” He may or may not ask questions. They may be questions about how to proceed, such as: “Do you mean who suggested I come?” or, “Do you want to know what made me think analysis would be a good idea?” or, “Are you asking me what's bothering me?” If, on the other hand, the potential patient understands my question, he may tell me

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why he is seeking treatment and then ask questions such as, “Can you help me?” or, “Is this something analysis can help me with?” These questions give me different information about my visitor, diagnostic information about how he should be treated. If the patient's questions are a plea that I tell him I can help him, and from his presenting problem I believe it is possible, and I want to work with him, I may respond by asking, “Shall we try?” In other words, in the initial session and until I understand him any talk on my part is based on what he asks for. The primary purpose of this phase of the treatment is to avoid injury to the ego of the people we talk to and to help them to talk.

Most people seeking treatment then express an interest in frequency and fees, although I have been surprised by some. I have had patients talk through the hour, expressing their dissatisfactions with life, telling some of their history until the last minute of the hour. When I stand up to indicate the end of the hour, they wait for me to say something. If I say nothing some may ask “Am I to return?” In response to this type of question I express an interest in what the patient wants. I might ask, “Would you like to?” Some ask, “Will you take me?” The question tells me more about the person. He may be a person who believes he has no say in his life. He is at my disposal. I have found that when this is the case, the patient may be surprised to be asked what he wants. It may not be his usual experience.

The same behavior is demonstrated around the subject of frequency and fees. When invited to begin, some patients may directly request a next appointment. Others will bring up fees. When the patient asks me how often he should come, or what fee he should pay, I cannot tell from his question how frequently he wants to come or what he wants to pay. If I have a fixed fee the frequency of sessions will be negotiated by the amount he can spend. If I have a sliding fee I will ask questions such as “How often would you like to come?” And in response to questions about fee, I will ask what he had planned to spend. In the ensuing dialogue we arrive at a frequency and a fee based on the patient's responses to these questions. I know many practitioners like to make the decision themselves about what frequency is desirable, and they may base frequency on the emotional condition to be treated; but I have found that the nervous system of the patient has a higher reliability in

decisions such as frequency, and if I allow it to dictate, within the framework of my availability, the patient's nervous system will keep me informed when it is time to increase or decrease the frequency of sessions. The patient may over-estimate his capacity and say he wants to come five times a week.

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I would want to investigate his readiness for this. If the patient wants to begin once weekly, I begin at that frequency when possible. Somewhere in these discussions both I and the potential patient have decided whether to work together.

I hope that I have demonstrated in this description of the first session what I am trying to convey to the patient. I hope to let him know my willingness to work with him, that I intend to consider his views and to cooperate with his requests. In the initial stage of treatment the analyst's cooperative attitude may be a new experience for the patient, and as the sessions continue communication of this cooperative attitude may be limited by the patient's intolerance for cooperation. Many patients make it clear early in treatment that they want a dictator—they respond well to commands. So in order for me to determine exactly what attitudes the patient can comfortably have me take and which I must hold in reserve, over the first few months of treatment I study the patient's style of contacting me during the sessions. Some of the questions I have found useful to explore this manner of contact are: “Shall I tell you what to do?” “If I tell you what to do, will you do what I tell you?” “If not, why should I tell you what to do?”

An important issue to be considered when beginning is: What quantity of stimulation will help the patient to be in the room with me and to talk. This is measured by the patient's style of contact. The patient's behavior during the session cues me to whether he is talking to himself, is alone in the universe, whether he recognizes my presence, whether he talks to me directly. Sometimes he makes vague references to my presence. One patient contacted me sparingly for six months. During that time she told me story after story of her early history. Suddenly, at the end of the 24th session, she sat up, turned around, and studied my face silently. Looking very much like a little girl, she said, “I've told you everything.” I waited. Then she said, “Does that mean the analysis is over?” And I thought, “Ah, now the contact begins.”

The analyst judges whether the patient is in an object transference or a narcissistic state. From the first contact with a patient a process begins that has the potential of bringing about change. Those who practice what has come to be known as psychoanalysis share one principle, regardless of school of thought—the principle that change takes place within the doctor-patient relationship. Most of us call this relationship the transference-countertransference matrix. I love to train writers to be analysts. They seem to know intuitively how to build a relationship. Literature reveals the skill of authors in creating

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both relationships that are therapeutic to others and those that destroy. Creating the relationship that will be therapeutic is the primary task of the analyst, who needs also to be aware of what can be destructive in the analytic interchange. Our problem with patients who have given up hope of getting what they need from others is how to bring them into a relationship with the analyst.

What is the nature of the relationship with the psychoanalyst? T. S. Eliot, author of “The Waste Land,” has expressed the task of the analyst very well.

> April is the cruelest month, breeding
> Lilacs out of dead land, mixing
> Memory and desire, stirring
> Dull roots with spring rain.

The analyst creates an environment in which the patient is comfortable and in which there will be a re-arousal of burning desires. He may be thought of as cruel, creating an environment like April in which memory can be reawakened and dull roots stirred.

We're all agreed that re-arousal, in the transference, of repressed or otherwise lost desires begins with the beginning of an analysis. However, it is not easy to breed lilacs out of the dead land. We have that other phenomenon known as defense.

The analyst must know the kind of transference and the degree of arousal that the patient is ready for. What kind of interventions are appropriate early in treatment to mix the therapeutic quantity of memory with desire in the transference relationship? Something that beginning analysts may lose sight of is that our concern in the

initial phase of treatment is not with making progress but with creating an environment in which the patient can give up his resistances to talking in the presence of the analyst.

To avoid intereference with the development of transference, I have found three tools invaluable in the opening phase of treatment; they determine the posture of the analyst.

The Opening Phase: Diagnosis, Contact Function, Ego Insulation

Diagnosis is important because it helps me gauge how much stimulation the patient can tolerate during sessions. A study of the patient's contact function helps me to understand the diagnosis. By

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contact function I mean his behavior during the session—whether he talks only to himself or recognizes my presence, whether he addresses himself to me, and how he does that. Is it questions, statements, demands, appeals for sympathy? Simply put, the patient's contact function is his way of reaching out to me during the session. His contacts guide me in what quantity and quality of communication he wants from me. Having informed me in the initial sessions of why he is there, and having been instructed to talk to me about whatever he wants to, he may conscientiously begin to tell me the story of his life. In that telling he may become a reconteur, not asking me any questions nor demanding anything. On the other hand, he may seek reassurance —"Am I saying the right thing?" "Is this what you want to hear?" Or he may engage in self-attack—"I know I should be saying more." "I should be feeling more … or feeling less." "I should not be so hateful."

One brilliant patient of mine comes to mind when I think about this, a man whom I have known in other settings. Everybody asks him questions because he is a learned man and knows the answers. As soon as he arrives at my door he forgets all the answers. In my office he cannot utter more than two or three sentences without asking me to tell him the answer. How do we understand this? This is a man whose family respected hims as a child. He knew more than his parents. He has been in the role of the superior one. What he has missed is a feeling of oneness with another human being.

This is the patient's style and the basis for diagnosis. Diagnosis then is rather straightforward. I might know the labels: paranoia, schizophrenia, mania, psychotic depression, but all I need to know is how he addresses me —if he does—whether in questions, statements or complaints. He reveals in his patterns for making contact several kinds of information. His contacts distinguish him from others by the severity of their defensiveness. If I exist as a real entity with transference distortions, I can say that he has a separate object field of the mind. If his contacts indicate that he is not talking to a person but shifting between inner and outer, projecting parts of the self onto the analyst, I gather he is talking about the split between acceptable and unacceptable parts of the self and I am confronted by the narcissistic personality. If the patient processes the stimulation of the analytic session by withdrawal from the here and now, I know the fragile ego needs to be insulated and I have learned that supportive interventions or kindly communications may not be desirable with the patient when he is operating in this shut-down mode. They merely lead to further bottling up of tension, on the principle that I am so nice, how can he hate me? There are

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other ways in which the patient conveys a need for distance, e.g., confused mental states, denial. In these cases also, my interventions must be planned to reflect his style of contact function because in that way I do not present the narcissistic or psychotic patient with the stimulation of another presence. I am his shadow. If the patient projects his destructive impulses or wishes, negative thoughts or affects, I discover by these contacts how I should respond to his projections. The projector does not need a contradictory perception, a person with another point of view, any more than he requires the analyst to be kindly or supportive.

The beginning of treatment involves me in a listening posture, free of interpretation of explanation. Exceptions are when the patient's mode of contact demonstrates that simple explanations, short and not too deep, will help him to talk. (The tit-for-tat dialogue: I'll tell you a perception; if you give me one back, I'll give you another perception.) Usually reflective questions that follow the patient's style of contact are desirable even in these cases, since we want to know the meaning of tit-for-tat before determining its desirability. Even the simplest mode of interpretation, confrontation, pointing out a patient's behavior or explaining its effects, even this leaves the patient feeling criticized or attacked and does not strengthen the ego functions. Conversely, it may intensify self-doubts.

Here is where diagnosis is useful. The narcissistic patient may respond to an explanation by feeling injured and in danger. The same explanation given to a patient who can distinguish self from other may be received as a criticism, along with the thought that the therapist is trying to get at something, wanting to probe to help the patient. This stance allows the neurotic to hear more about himself from the other's point of view—without increasing his defensiveness in warding off the environment. Most of our patients, however, do not begin treatment with this degree of self-assurance; a bad opinion, a criticism by the analyst, can cause the patient to question himself. If an explanation silences a patient or leaves him with an "if you say so" attitude, I have failed to help him to say everything that he needs to say.

I mentioned insulation of the ego. The ego is insulated and protected from further injury by such techniques as joining or reflecting. Those patients whose style of contact reveals a reliance on the more severe defenses are telling us that they are in danger from any analytic input and cannot be related to in the same way that they can when the diagnosis changes. I arrive at a new diagnosis when the patient's contact function changes. A patient who has been communicating through indirect expression, through action or symbol, may,

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following a period of joining, feel more comfortable with the direct expression of feelings. I continue to study his style in verbal exchanges as he is helped to convert communication patterns from instinctual, symbolic levels to impulsive levels and finally to emotional communication, in a proper feeling experience with the analyst. If, during the early phase of treatment, I am successful in staying with the patient, neither over nor understimulating him, maintaining his defenses so long as he needs them, the patient may become a person who can engage successfully in emotional communication. If he can convert action and symbol to direct experience with access to his thought and feeling, he is emotionally alive and ready for the rest of the world.

The Analyst's Longings

I have spoken of how the patient is diagnosed and observed as he makes contact, and how arousal is controlled in the analytic office. The analyst, from the first contacts with the patient, is also responding to feelings the patient arouses within her. The response is a silent response. She will use most of her feelings later in the treatment. As you can see there is not much room for interpretation so far and there is not much vale in exposing my own personality, thoughts, or feelings.

It has been said that transference will occur naturally within the course of the analysis, and we do believe this would be true were it not for the presence of the analyst with his own personality. During the first two years of treatment, the period in which a transference may unfold, the analyst's personality can be a detriment to the development of a transference and can lead to the termination of treatment; or, equally disastrous, to the development of an object relationship with the analyst when, for therapeutic purposes, a narcissistic transference would be more desirable.

One of the most important phenomena we find when training beginning analysts is that they want to make progress. When they don't they develop self-doubts, even resort to narcissism. One of the difficulties in training beginning analysts lies in teaching them that they are not supposed to make progress in the beginning phase of treatment. More important than progress is the ability to resonate with a patient, an important and necessary process in the treatment.

We have learned that what the patient feels, even the feelings hidden from his awareness, influences the analyst. These feelings arouse the analyst's memories and desires, they stir her roots, and they influence

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the analyst to merge with and repeat the patient's past, either in the identification with the patient or with the objects in the patinet's history. The analyst's feelings are problematic only when the process takes place outside the awareness of the analyst and if it results in loving too much or hating too much and in communications that act on these feelings. This week I saw a patient who came in an extremenly agitated state. He teaches a course on countertransference at one of the analytic institutes in the East. He said he was disturbed because each week when he entered the classroom, a very attractive young woman smiled broadly at him and he didn't know what to do. I investigated with him what he meant and he revealed that if he smiled back there was no telling what would happen. As we discussed this class and his problem with it, he said he didn't want the other students to feel that he preferred this woman. She then wrote logs to him, communicating: "I don't know what I'm doing

wrong. You seem so cold to me. I don't know what the problem is.” I explored with him the consequences if the students felt he favored her. He said that they would become very angry. By now in this interview I know the man is afraid of sex and is afraid of aggression. He's also afraid that this students will have feelings. The young woman experiences him as being stiff. He believes that these feelings can be avoided and that in that way he can run an orderly classroom and he believes that if feelings are allowed, action will follow.

We have learned that emotional induction is necessary because it provides the means of knowing what it is like to be the patient. Feelings are used when necessary to assit the patient to talk. For example, my patient who fears arousal of rivalry in his classroom would want these feelings expressed as a demonstration of the value of talking in the treatment. We want feeling to exist and be felt in an analysis. It is through the creation of language that the patient becomes whole. For decades we believed we could find the right things to do or say that would help patients to get well. Now we know we must be free to feel all feelings; now we know that the patient can hear anything from the therapist whom he experiences as feeling the feelings he needs. If we work with a patient over many years we can expect to develop feelings for the patient that he needs and did not get to help him to grow.

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