amenities of the professional relationship are consistently observed. He greets the patient courteously on arrival, gives explanations in a polite manner, and does not show offense at insulting or provocative remarks. He conveys the attitude: My feelings are not important. What is important is getting to know you.

Self-command entails the ability to tolerate the mistakes one makes without being unduly disturbed by them. It is often easier to absolve a sense of guilt by confessing or denying them. But to admit or deny one's errors to a schizophrenic patient before he is able to verbalize his resentment freely is rarely desirable. If a patient accuses me of making an error, I may ask him, "Assuming that you are right about my making a mistake, where does that lead us?"

Usually the patient wants to know if the analyst, over and above his professional commitment, is really interested in helping him. There is always some testing-out on that score. Instead of either denying or admitting personal interest directly, it is often a good idea to investigate with the patient the therapeutic implications of granting or refusing the special requests he makes or the favors he seeks. The analyst presents himself, in effect, like the gruff parent doing his duty. Eventually the patient recognizes that the analyst is genuinely interested in him and has been permitting him to make that discovery for himself.

Chapter 10

INTERVENTIONS: RANGE AND SEQUENCE

The basic "psychosomatic" function of speech (the central vehicle of psychoanalysis) I regard as the original bridge over separation between mother and infant, continuing in adult relationships, largely replacing the original bodily intimacies.

—Leo Stone (1981a, p. 97)

Voluntary communication with a patient in the analytic sessions is of two types: one can be silent or one can talk. Silence is mentioned first because, measured in time, it is the more important—and more difficult—activity. As the matrix for effective nonverbal communication, the analyst's silence also catalyzes or permits growth in the preoedipal personality. Nonverbal communication goes on even though voluntary silence is maintained.

Early in treatment, for instance, when the patient developing a narcissistic transference requires a virtually inanimate presence—preferably someone who does not even breathe—*motionless silence* communicates the message: I do not want to disturb you in any way. *Shared silence*, characterized by unobtru-

sive changes in position, tells a person who in one way or another has been expressing a wish to be silent that the practitioner is not waiting impatiently for him to talk. Fidgeting, coughing, and jerky movements create a *restless silence*, which may tactfully convey the contrary message.

The decision to intervene—that is, to communicate voluntarily—is a matter of theoretical significance. In order to maximize the patient's own capacity for successful functioning in life, the psychoanalyst, as a practitioner of indirect psychotherapy, observes the principle of parsimony in communication. Since it is desirable that the patient's personality should be the product of his own input, the therapist exerts no more influence than necessary to facilitate the sought-for changes in the patient's behavior. Interventions are made primarily to resolve resistance.

That was the purpose Freud had in mind when he reported on his psychotherapeutic activity in Chapter IV of the *Studies on Hysteria*. His first formulation on technique also suggests both the broad range of resources at the practitioner's disposal for removing the "continual resistance" and what he strives to accomplish by doing so.

These resources, Freud states, "include almost all those by which one man can ordinarily exert a psychical influence on another." Patience is advocated because resistance "can only be *resolved slowly and by degrees*" (emphasis added). Reckoning on the patient's development of intellectual interest, one may, by "explaining things" and giving information about psychical processes, turn the patient into a collaborator, and "push back his resistance" by inducing him to regard himself with "objective interest."[1] Once the motives for the patient's defense have been discovered, the "strongest lever" is to "deprive them of their value or even to replace them by more powerful ones."

To the best of one's power, Freud continues, one works as

[1]Rather than bank on the development of intellectual interest, I recommend that explanations be withheld until the patient displays a genuine interest in obtaining them. The schizophrenic patient rarely demonstrates a hunger for intellectual information before completing several years of treatment.

elucidator, teacher, and father confessor, giving absolution with sympathy and respect. One gives, too, as much human assistance as one's personal capacity and sympathy for the patient permit. An "essential precondition" for this activity is to divine the nature of the case and the motives for the defense, for the patient frees himself from his hysterical symptom by "reproducing the pathogenic impressions that caused it and by giving utterance to them with an expression of affect, and thus the therapeutic task *consists solely in inducing him to do so*[2] (Breuer & Freud, 1893–1895, pp. 282–283).

But disappointments ensue if one banks on arousing the schizophrenic patient's intellectual interest or tries to woo him into collaboration with human assistance and sympathy. Even today, some analysts recommend a warm and outgoing manner to establish a relationship with a schizophrenic patient. In my experience this is *contraindicated*. Instead, it is desirable to maintain an attitude of reserve, to be cool, *until* the patient has developed the capacity to release hate tensions comfortably in emotional language and, in addition, displays a strong intellectual interest in cooperating in the treatment and in understanding it. Otherwise, the information may be utilized destructively.

Nevertheless, Freud's earliest account of his technique, unencumbered as it is of strictures against noninterpretive communications, conveys admirably the purpose and spirit of interventions in a case of schizophrenia. The reference to patience is eminently pertinent. It applies not only to silence but also to saying one thing over and over again with all the verbal dexterity at one's command. The repetition is essential. Like a young child, the schizophrenic individual has to be *induced* to master the obstacles to intrapsychic growth, without being exposed to undue pressure. This is, inevitably, a gradual process.

The principle of intervening only when and as much as necessary to resolve resistance transcends unrealistic dichotomies in technique, such as that between the so-called passive and

[2]An important precondition, as viewed by the modern psychoanalyst, is that the patient's resistance to reproducing the pathogenic impression be resolved with the help of the analyst.

active approaches. In recent years the need for *specificity* has received growing emphasis—varying degrees of activity and inactivity and the precise types, or series, of interventions that would effectively resolve the resistance being worked on at the moment. With some schizophrenic patients, it is possible to function silently for long intervals; other patients require a great deal of activity immediately. Moreover, as patterns of resistance change in the course of the treatment, so too do the types of interventions to which the patient responds. Indications and contraindications for dealing with these patterns constitute the basis for a comprehensive and logical system of interventions.

Competently trained practitioners, regardless of their theoretical orientation, are usually well versed in the various techniques needed; however, guides to administering them with maximum psychological effectiveness are lacking. The beginner in the field tends to base his interventions on a priori notions that certain types are necessary, rather than giving consideration to what each might, or might not, accomplish in a given situation—the important factor.

An intervention is of value only when it helps the patient move out of a pattern of resistant behavior that is being engaged in "right *now*." He may express attitudes that are immature or irrational, but as long as he is verbalizing these spontaneously and with affect, nothing is gained by interrupting him to conceptualize the attitudes. The value of an interpretation of content is determined by its immediate impact on the here-and-now resistance. When a patient is not functioning cooperatively, it is a good rule of thumb not to intervene until one understands the current resistance and has decided what to do about it.

The beginner may have difficulty, too, in grasping the principle of sequence in interventions. This applies not only in dealing with a single manifestation of resistance, which usually entails a series of communications, but also in responding to its myriad manifestations throughout the case. As the general character of resistance changes, any one type of intervention may become more or less necessary than it was at earlier stages of treatment. The sequence itself is not invariable; it has to be *discovered* for each patient.

By and large, however, effective interventions in a case of schizophrenia move in the direction of more complex levels of communication, ranging from commands and brief questions to explanations and interpretations. The unconscious communication in the order in which they are introduced is that the analyst understands the patient's need to assimilate simple communications before tackling more complex ones. The psychology of verbal feeding parallels the principle of infant feeding—no solid food on a regular basis until it is psychologically digestible.

Any type of intervention that helps the patient say what he really feels, thinks, and remembers without causing narcissistic injury (Lucas, 1983) is designated as a *maturational communication*. Early in the case, a brief question that helps the patient articulate impressions of external realities (an aid in managing the fragmentation resistances that usually develop when interest is shown in his symptoms, dreams, and fantasies) is a maturational communication.At the other end of the continuum is the interpretation that is given when requested, and when it will help the patient articulate his own thoughts and feelings. (Interpretations given in the line of duty to share an insight with the patient without regard for the immediate consequences may have the contrary effect.) The therapeutic intent underlying the maturational interpretation is to help the patient talk progressively, rather than repetitively.

Many communications that have a maturational effect reflect the old adage: If you can't lick 'em, join 'em. The analyst often responds to a "stonewall" resistance in that spirit, whether to bring the resistance into focus, to manage it, or to help the patient outgrow the need for it. The term "joining" denotes the use of one or more ego-modifying techniques to help the patient move out of a repetitive pattern.

Indirectly, by reducing the pressure for impulse discharge, the joining of resistance has the effect of reinforcing the preoedipal personality. Conceptualized in different ways, this approach figures in various systems of psychotherapy—e.g., Viktor Frankl's technique of paradoxical intention (1960)—although its value and indications for its use are not always specified. Resistance-joining, in my view, should be employed in indirect

psychotherapy only to help the patient function cooperatively in the treatment relationship by removing an immediate obstacle to communication. The resistance is joined, positively or negatively, for the express purpose of helping the patient give it up.

The patient's words may be repeated, with or without feeling, in a question or declaratory statement. As has been pointed out (Eissler, 1958), the effect of such repetition may be equivalent to an interpretation. An unverbalized attitude may be joined. But resistant *behavior* in the sessions (acting in) is outside the realm of resistance patterns that are supported. The therapist frustrates it by a calm and contemplative attitude, or discourages it more actively when the behavior is clearly destructive to the treatment.

In presenting the innumerable emotional confrontations engaged in to manage a "stonewall" resistance, monotony is avoided. Genuineness of feelings, based on the objective countertransference, and freshness of encounter make important contributions to the effectiveness of these communications (Davis, 1978).

Some are experienced by the patient as pleasant, others as unpleasant; the difference often depends on the tone of voice in which the intervention is made. When the effect is ego-dystonic, negative feelings are mobilized and defenses against verbalizing them are activated. When the patient talks disagreeably, agreeable joining may mitigate the strength of the resistance to being disagreeable. (I have observed that initially supervisees tend to feel that they "said something wrong" when a patient verbalizes a negative reaction to an intervention, but eventually they learn that helping the patient develop the ability to express negative as well as positive feelings is one of the aims of the treatment.) Agreeable joining may result in the patient feeling comfortable and understood. When ego-syntonic communications mobilize positive feelings, the therapist works to reduce the patient's resistance to verbalizing them.

In the section that follows, types of interventions that are frequently and productively employed with the schizophrenic patients are illustrated. These characteristic communications are discussed in the sequence in which they are usually presented

in the course of the treatment. The interventions include commands, questions, explanations, joining, mirroring, and reflective procedures, and maturational interpretations.

Sequence in interventions is then discussed in the context of transference resistance. Successive approaches to the dominant resistance—the pattern of bottling up destructive aggression in its myriad forms—are illustrated.

COMMANDS (ORDERS)

The preferred intervention when the treatment gets under way is the command. Commands are not issued to secure obedience. The therapist's intent, rather, is to find out whether the patient wants to obey or defy and to help him communicate why he wants to do so—in other words, to mobilize resistance and, eventually, to resolve it.

"Lie on the couch and talk" is a typical formulation of the fundamental rule for the schizophrenic patient. Instead, he may be ordered to "tell your life story" or "talk." (As already pointed out, the patient is *not* asked to engage in free association.) Pertinent reminders of the rule are phrased in similar terms.

Commands that are formulated in terms of the patient's resistive attitudes are often effective. The patient may say, for example, that he is not going to talk any more. A reminder that he is supposed to talk tends to intensify the resistance of a negatively suggestible person, but if he is told, "You've talked too much. Keep quiet for the rest of the session," he may reply, "I will not"—and continue talking.

To give another example: commanding a patient who is out of control to cry has the effect of restoring his control so that he continues to talk. One may speculate that as a young child the patient was told by a parent: "Don't cry." Instructing him to cry reverses the pattern. This is an example of positive versus negative mirroring, based on paradoxical intention.

An explanation of the realistic basis of the command is more likely to resolve the resistance of a positively suggestible person. For example, in reflecting the resistive attitude of a woman who "really didn't want to" remain on the couch, the

therapist said that this was not mandatory but preferable. He then helped her to verbalize all of her objections and these were discussed. Some of them had some validity and this was readily conceded. The therapist said, "I am not trying to make you as comfortable as possible, but to do what is best for the treatment." The woman raised no further objection; the explanation also helped her to recognize that she had the right to assert herself in the relationship.

Countercommands may be issued. When ordered to do something by the patient, the therapist may say, "You do it." A patient who commands the therapist to "Keep quiet, " may be told, "You keep quiet too." "Tell me," "Say it," and other brief statements in the imperative mood are often made.

Marshall (1982) illustrates a number of joining techniques "oriented toward supporting *and* resolving narcissistic resistances" (p. 62), which he regards as the interventions of choice in dealing with preverbal patterns. On the use of a similar technique with a negatively suggestible nine-year-old boy who engaged in assaultive behavior in treatment sessions, Marshall reports:

> As I became more aware of his extremely contrary nature while I tried to set limits, I ordered him to act in a destructive manner. Behind a barrage of "Who says so?" "Who's gonna make me?" etc., he behaved in a pleasant manner, but lapsed into silence. I then ordered him to maintain his silence, at which point he launched into a series of reproaches, arguments, etc., which revealed important material and provided grounds for discussion. Later, when I ordered him to speak unpleasantly to me and not about nice things, he spoke of the fun of his vacation. (p. 69)

Because the therapist in this instance orders the patient to engage in resistance, Marshall refers to the technique as "prescribing the resistance" (p. 69).

For patients who do not respond to questions, commands may serve as effective alternatives. I became aware of this many years ago when a young woman indicated that she could not tolerate being questioned. When I asked her why, she could not give an immediate explanation. Eventually she recognized that her distress at being questioned reminded her of a very painful period when, following an appendectomy, she developed an abscess. She continued, "My doctor came in every day and put a probe into the wound. And every time you ask me a question, you put that probe in again. I can't stand it." When I inquired whether she could stand being given orders, she said, "Order me all you want to." Eventually that solved the problem.

On the other hand, one occasionally encounters a patient who responds angrily when commanded to do something or feels that he is being attacked. Apparently, what matters is not whether one questions or issues an order to a patient, but precisely what that communication suggests to that patient—how it is being perceived (Spotnitz, 1981b). One needs to begin employing an intervention tentatively while studying its effectiveness and adapting it to the needs of each patient.

QUESTIONS

Commands are usually followed by questions. These may be positive (expressing interest) or negative (expressing depreciation, or meeting dissatisfaction with dissatisfaction). In addition to initiating questions, the therapist usually counters the patient's questions with questions.

At the beginning of treatment, the therapist usually asks only factual or object-oriented questions. It is preferable that these be posed when the patient addresses the therapist. As Meadow has pointed out, "Contact functioning replaces the subjectively determined timing of classical interpretation with what might be called "demand feeding," in which the timing and type of communication are what the subject asks for" (1974, p. 92).

Factual Questions

Because of the patient's characteristically vague manner of reporting an external event, it may be opportune to query him

about such elementary details as when and where it occurred. The patient may also be asked for the names of people he has mentioned, or to identify books, theatrical productions, and the like by title. To reassure a patient who becomes anxious about doing so, the analyst may let him know that he (the analyst) is interested in obtaining the facts.

Questions may also be asked to clarify or highlight the repetitive nature of the patient's communications. A patient bogged down in fulsome praise of his parents may be asked, "Are your parents really wonderful people?"

Grilling for Evidence

Without in any way challenging the validity of a delusionary idea, the analyst may investigate it with the patient. Investigations of that nature are appropriately carried on late in treatment.

For example, after at least a year of treatment, a patient who attributes some feeling of his own to the analyst may be asked to provide the evidence. A series of questions (condensed) that helped a patient recognize that he was projecting his own anger is presented below.

[P (shortly after entering the office): You are angry at me.

A: What makes you think so?

[P: When you opened the door you had an angry expression on your face.]

A: Did I look angry when you left here yesterday?

[P: No. You smiled in a rather friendly way.]

A:Then why should I be angry with you today?

[P I don't know why. Come to think of it, as I was coming here today, I began to feel angry at you because you didn't answer that question I asked you in the last session.]

A: Why should I be angry at you because you are angry at me for not answering that question?

[P: Maybe you aren't. But I thought you were because I was angry at you.]

A: How are we going to settle this question?

[P: It's settled. You aren't angry at me. I'm angry at you.]

The analyst may also ask one question after another when the patient "egotizes" (introjects) feelings. When, for example, a woman said she was very fatigued 15 minutes after entering the office looking fresh and vigorous, the analyst asked, "You've been coming here so often at this hour, and this is the first time you've complained of fatigue. How do you account for it?" She tried to do so on a realistic basis. After each explanation she advanced was investigated with her, she began to suspect that the feeling of fatigue might not be connected solely with her own experience. Further questioning led her to conclude that she had detected signs of weariness on the analyst's face when he opened the door to the consulting room. And she had not wanted to say so, she explained, out of fear of displeasing him.

Object-Oriented Questions

The second series of questions, countering the patient's introspective tendencies, draws attention to external objects as a factor in the patient's repetitive communications. Margolis (1983b), in a detailed discussion elucidating the significance of the object-oriented question, emphasizes that its basic function is to resolve resistance to communication. Its uses for that purpose, Margolis adds, "embrace a range of occasions extending from the solely protective to the most complex analyst-patient transactions" (p. 37).

At a time when the patient has been complaining repetitiously, for example, the therapist may inquire, "Have I been disturbing you?" or whether someone has been disturbing the patient at home. A patient who has been crying may be asked such questions as "Did I do something to upset you?"; "Am I causing you unhappiness?"; "What can I do to make you more comfortable?"

By verbally assuming some degree of responsibility for the distress, the therapist draws attention to what others might have done to cause it or might do to alleviate it. The questions often suggest that the therapist is a person of unlimited power. (Examples of this "egomaniacal" approach are given later.)

Ego-Oriented Questions

Questions that direct the patient's attention to his own functioning are rarely asked in early stages of the relationship.

Eventually, the schizophrenic patient becomes capable of talking about himself in an emotionally significant way, and when he demonstrates that he can do so without becoming more self-absorbed, the analyst begins to pose a third type of question. Three series of ego-oriented questions that are often asked late in treatment are illustrated below.

The key to analytic cure. A person who has been complaining about his own inadequate functioning may be asked what he expects to accomplish through the complaint. An investigation of his wishes and expectations often leads to a discussion of his ideas about how the treatment should be conducted. The drift of the questioning is suggested by the interchanges that follow.

A: Suppose you convince me that you are as inadequate as you say you are, where does that lead us?

[P: That will help you treat me.]

A: How will it help me?

[P: Then you will understand me.]

A: How will my understanding help you?

[P: It will help me get well.]

A: Understanding alone doesn't help anyone get well. I have been demonstrating understanding and you are not getting better.

[P: Then how am I going to be cured?]

A: What cures you is dealing successfully with whatever interferes with your talking out your feelings, thoughts, and memories as they occur to you here.

Investigations of the patient's theories of analytic cure continue until the initial resistances to progressive communication are given up. This may take weeks or months.

The patient's expectations. Rather than pointing out directly that a pattern of resistant behavior is motivated, consciously or unconsciously, by an unrealistic expectation, the analyst may insinuate as much in the course of tactful questioning.

A severely disturbed young man who was asked how he thought the treatment should be conducted said he would like the therapist to "behave differently." In response to further questioning, he said that he would like the therapist to suffer as much as he did, to say things that would help him feel better, and not to charge for the treatment.

The therapist replied that he would consider suffering with the patient, giving him free treatment, and communicating what he would like to hear. "But I would like you to explain to me how such behavior would help you get well."

When the patient's ideas are repeatedly explored with him, he usually gets to recognize that they will not further treatment. He may then be willing to consider the therapist's plan of operation and stop working at cross-purposes.

The analyst's shortcomings. During the transitional phase (oscillating transference states) the patient may be asked for his impressions of the analyst and his problems. The usual reaction is surprise or indifference. He doesn't really know the analyst; hence his views would be of no value. Such questions should be put to someone more competent to answer. It is frequently suggested, "Return to your own analyst if you need help."

But the practitioner conveys the idea that what he wants to hear are the patient's impressions. "You are sensitive to people. If you will tell me what you think of me and help me with my problems, perhaps I can be more helpful to you and other patients."

EXPLANATIONS

When the treatment is undertaken, explanations of its requirements are brief, and given primarily in response to direct questions from the patient. It is repeatedly stated that whatever the analyst says in the sessions is said just to help the patient talk out the feelings, thoughts, and memories that occur to him at the moment—not to influence his behavior outside the relationship.

Occasionally, as a means of facilitating rapport, the analyst volunteers information on subjects raised by the patient—the news of the day, social and cultural events, and the like. In such

discussions, the analyst does not voice personal opinions. He presents different points of view on controversial topics and consistently parries the question, "What do *you* think?" Explanations of behavior follow the same pattern. The patient is helped to verbalize impulses to engage in destructive behavior as well as constructive behavior, and the possible consequences of each course are delineated. Alternative solutions to a problem are explored, and their respective advantages and disadvantages are pointed out.

After the first year of treatment, explanations of unconscious mechanisms are provided at the patient's request. While the narcissistic transference is evolving, however, such explanations are communicated mainly to control the frustration level rather than to promote understanding.

During the transition from the preoedipal to oedipal phases of the treatment, information is given when it would facilitate communication and withheld when it would have the contrary effect. Asked, for example, if he has read a book mentioned by the patient, the analyst may say, "Why do you ask?" If the patient replies that he would like to discuss it, he may be told, "It is better to discuss the book without knowing whether I have or have not read it." The patient, if cooperative, will then verbalize his impressions of the book. The analyst may then say, "I have (have not) read the book."

Although he does not answer questions that would make it easier for the patient to report his own experiences and perceptions, the analyst usually confirms an accurate perception of himself as a person after it has been adequately explained. Asked, for instance, if he was taking a walk in Central Park Sunday afternoon, he may say, "Why do you want to know?" The patient who replies, "I thought I saw you there," is asked for concrete details. After he reports the exact time and place, the analyst may say, "You are correct."

As the patient reveals more and more about himself, the therapist is justified in revealing some information about himself. In the process of helping the patient to undress psychologically—to reveal his impulses, feelings, thoughts, and memories—it is usually desirable for the therapist gradually to shed the anonymity that necessarily cloaks him, as a transference object, at the beginning of treatment. From the point of view of developing a more equal relationship, the more emotionally mature the patient becomes, the more the patient is entitled to know about the analyst; eventually, the stage is reached in which the patient gets to know a great deal about the analyst as a real person. In other words, as the patient improves, the welcome process referred to as "dissolving the transference" goes on. After the transference resistance has been resolved, there is no justification for the therapist remaining a phantom figure.

Hiding behind one's professionalism is an attitude that patients resent—justifiably. To be treated as an inferior by their partner in a prolonged, intimate, and deeply human relationship is an example of irrational deprivation (Stone, 1981b), as well as a humiliating experience. I emphasize this fact after encountering a goodly number of beginning therapists who labor under the impression that they are not supposed to reveal any information about themselves no matter how many years they work with a patient.

Joining Techniques

Preoedipal resistance patterns are rarely responsive to objective understanding. The term "joining techniques" is loosely applied to a number of basically similar interventions to manage these patterns, particularly those reflecting preverbal functioning. In making the interventions, the therapist supports and may even reinforce continued operation of the resistance until the patient "develops the awareness and ego strength to replace it with a more adaptive and controlled behavior pattern" (Marshall, 1982, p. 87).

Examples of various joining techniques follow. By and large, all of these interventions communicate the same message to the patient: I am like you. Which strategy is employed to convey this idea depends on what the therapist has to do to appear like the patient.

Joining and mirroring are both ego-modifying techniques. They are employed to deal with preverbal resistance patterns,

usually those containing aggressive impulses that were stultified. In joining a resistance, the therapist agrees with the patient's words or his conscious or unconscious attitudes. In mirroring, the therapist operates as a twin image. The patient wants to make contact with agreeable, similar objects, and will attack a dissimilar, disagreeable object if he feels it is safe enough to do so. The formula seems to be as follows: If you are enough like me and like me enough, it will be safe to attack you if I am convinced I will not be injured in the process.

Ego-Dystonic Joining

Ego-dystonic joining is employed primarily to facilitate the discharge of negative affects. Various examples of this approach are illustrated below.

Weather. When a patient complaining monotonously about the weather asks, "Isn't it pretty nasty?" the therapist may say, "Do you think it could have something to do with the barometric pressure?" On another occasion he might respond to the same question by asking, "Do you think the weather is hexing you?" or "Do you think it reflects your nasty disposition?"

Falling apart. In working on a compulsive repetition the practitioner may question the patient for some time and then make statements that reflect the pattern, whether faithfully or in a somewhat exaggerated manner.

A patient who repeats that he is becoming confused, feels unreal, is losing his bearings—"falling apart," as he often puts it—may first be asked some factual questions. For example, when had he first experienced such feelings; were they troubling him that very moment; could they be connected with something happening in the session? Should he continue to complain, he may be asked if the analyst might be arousing the feelings. The patient may then be asked, "What reason might you have for making yourself fall apart?"

Instead of asking a question, the analyst may say that he feels unreal and confused too. As he repetitively reflects the pattern blocking emotional release, he may indicate different degrees of confusion—"somewhat confused, but not as much as you," "much more confused," and so forth.

Saturating with suggestions. If the patient seeks advice, the practitioner may ask, "What makes you think that I will advise you?" The frequent retort, "I'm paying for it!" may meet with the reminder, "You are paying me to analyze you, not to advise you."

Often the analyst saturates the advice-seeker with suggestions or recommendations. Many possible courses of action are objectively outlined, and the patient is helped to verbalize freely his reactions to each alternative.

But this approach rarely satisfies him. Usually he wants to know "what you would do in my place." The therapist may then inquire, "What difference would it make to you if I tell you what I would do?" If the patient answers that the information would influence him in making his own decision, the analyst may say, "Why should you permit me to influence you in any way?"

Meeting threats with threats. "No action, just talking please," the analyst may say. His reminders that all force is to be turned into language may be gentle, pleading, persuasive, or phrased more sternly.

A person who threatens to leave "if you don't talk to me" may be told, "If you don't talk the way I want you to, I may terminate this session now." Obscenities and insults may be countered in similar vein.

When a college student stubbornly maneuvering for control hinted that his father might not let him come any more, the analyst said, "Unless you get your father to agree, I may stop the treatment." Another young man, trying to force the analyst to talk to him, shouted that he would "get off the couch and bash your head in." The analyst responded, "I'll bash yours in before you can get off the couch."[3]

Echoing the ego. In illustrating this ego-strengthening

[3]Repetition of the threats serves to assuage the patient's guilt about them.

procedure for highlighting a pattern of self-attack, Nagelberg and Spotnitz (1958) hypothesized that it might have the effect of reversing the "original process of ego formation, when the infantile mental apparatus failed to release hostile feelings toward its earliest object since the latter was experienced as being too distant. . . . contribut[ing] to the formation of a pattern of directing these impulses back upon the mental apparatus" (p. 796). Of interest in this connection is the observation that schizophrenic patients use echopraxia (repetition of actions seen) to get close to another person (Day & Semrad, 1978).

In employing the echoing procedure, the analyst may say, "I agree with you" to a person who has been low-rating himself, or repeat his statement with some degree of exaggeration. A patient harping on the idea that he is the "worst person alive" may be told that he is the worst "who ever lived." Usually he indicates that, though he is really as worthless as he presents himself, he would rather not hear the analyst say so. Convincing echoing of this nature thus has the effect of eventually shifting the target of the attack from ego to object.

Repetitive evaluations of the superior or mediocre "I" may also be greeted with a "yes you are."

Overevaluating the object. Instead of echoing the ego, the therapist may present himself as its psychological twin. In the process of reflecting the patient's repetitive evaluations of himself as the "greatest," the therapist talks at times like an egomaniac. Highlighting the vainglorious attitudes of an extremely self-centered person, he may say, in effect: I am all-powerful, omniscient, the only person in the world who can help you. This series of interventions usually fosters the development of the "idealizing" aspect of the narcissistic transference.

Devaluating the object. At other times, in mirroring the patient's sticky references to himself as the most inadequate or contemptible of human beings, the analyst chimes in with a "me, too!" He presents himself as depressed and humble, proclaiming, in effect: I'm a failure too. The patient's attitude may be reflected faithfully or in a somewhat exaggerated manner.

Powered with the emotional charge of the objective countertransference, this series of interventions is presented *after* the patient has acquired some feeling for the analyst as an external object. The characteristic aspect of the narcissistic defense—the lowly ego prostrating itself before the wonderful object in order not to risk the loss of its valuable services—is worked on in this way for the purpose of facilitating the discharge of aggressive impulses.

Almost inevitably, the time comes when both parties feel that the treatment has failed. The analyst's interventions (summarized here)[4] genuinely reflected his feelings at the time the interchange reported below took place. In that session, his efforts to reverse the flow of mobilized aggression from ego to object proved successful. The mirroring procedure resolved the patient's resistance to "letting go" (relaxing defenses).

A young woman complained that she felt like a "lifeless shadow." She couldn't assert herself in social situations; besides, she was never asked out on dates.

A: Obviously I haven't helped you.

[P: I apologize for painting such a gloomy picture. It is I who have failed, not you.]

A: I have failed you.

[P: You make me uncomfortable when you say that. I prefer to think that I am at fault. I tell you I'm a failure to annoy you but I'm really not because I don't do or feel a thing.]

A: I'm responsible for that.

[P: You can show me how to walk but you can't walk for me. What's the point of blaming you if I don't want to move? In a way, though, you're right. I ought to be wanting a husband instead of always sitting alone and doing nothing. Now you're making me feel terrible. Why must you get me so worked up about things? I hate to say it, but you really should have helped more than you have. No, that isn't true. I haven't cooperated. I should have talked more freely.]

A: You have talked freely.

[P: Are you certain? You're right. I've told you everything

[4]The dialogue is reported more extensively elsewhere (Nagelberg & Spotnitz, 1958, pp. 799–800).

but it hasn't helped. What about all the time and money I've put into this treatment? If you get me to believe you, I'll be too mad to ever come again.]

A: Why can't you be mad and still come? Even if I have failed, all this can change. I can begin to understand you if you'll help me.

[P (shouting): That would be a cheap way out for you, but if you haven't helped me by now, you never will. Besides, since when is it *my* job to help *you*? If you need help, go and see an analyst yourself.]

A: You have spoken freely here, but you have not attempted to help me make you as popular as you want to be. We could work together to accomplish this if you would display more initiative.

[P: . . . I hate you too much to help you. My foot! I'll help you into the grave. If I let it sink in that you've botched up my treatment, I'd go crazy, scream, and cut my throat. No! It's you who ought to go to prison for getting me into such a state. I was too nice to tell you what I thought of you before, but now I'm so mad I don't care. I ought to report you and sue you for my money. If I tore you to pieces I could plead insanity and get off scot-free. . . . You've gotten me into a mess and now you'll have to get me out of it.]

A: Why don't you get *me* out of it?

[P: I wouldn't lift my little finger to help you. (laughing) You see how I hate you when you don't let me have my way. If you won't let me win, I won't let you either, even if my whole treatment goes up in smoke. Now you see how furious I can get when I let myself go. And there's still plenty of anger inside me.]

"Outcrazying" the patient. The therapist, talking in a serious manner, may carry to the point of absurdity a harebrained scheme or unrealistic idea preoccupying the patient. [*Exaggerated mirroring*]

A man who harped on his intention to publish books on microcards was asked if he had also considered the possibility of publishing newspapers, bankchecks, and personal letters on microcards. It was suggested to another man, boasting incessantly of his ability to design a motion picture projector that would make him a fortune, that he ought to invent one that would flash pictures on a screen in a distant location. "You're a real crackpot," he exclaimed.

Through such interchanges, the notion emerges that if the analyst, with all his crazy ideas, can live in the real world, the patient too should be able to cope with it.

Suicide or patienticide. When the patient verbalizes self-hatred and thoughts of suicide, the analyst may say, "I hate myself. I feel like committing suicide too." (An illustration of *egodystonic, negative mirroring* leading to verbal attack on the object.)

[P: You don't mean it. Why would *you* want to kill yourself?]

A: Do you think I like to sit in this dark room hour after hour listening to a hateful person like you?

[P: Go drown yourself!][5]

An ego-oriented approach (ego-dystonic joining) to the same repetitive pattern may eventually be employed when the practitioner can comfortably communicate murderous feelings for the patient who habitually talks of wanting to destroy himself. A series of interchanges (over many sessions) that led to the externalization of the patient's impulse to kill is outlined below.

[P: I hate myself. I feel like killing myself.]

A: Sometimes I hate you and would like to kill you.

[P: You wouldn't do it. You don't hate me.]

A: Why wouldn't I hate you? Why wouldn't I feel like killing you?

[P: Maybe you do feel like killing me, but I'd rather do it myself.]

A: If your life really isn't worth living, why deprive me of the pleasure of putting you out of your misery? You're entitled to a mercy killing.

[P: Do you really mean it?]

A: Why shouldn't I mean it? Some physicians recommend

[5]If the patient expresses sympathy, the intervention is unsuccessful, its purpose being to facilitate the verbal discharge of aggressive impulses.

euthanasia to relieve intolerable and interminable suffering. I might be glad to cooperate.

[P: How would you go about it?]

A: There are plenty of ways to do it. I'll describe them and you can take your pick. Would you like to leave a suicide note?

[P: I'm beginning to think you would really enjoy killing me off.]

A: Why shouldn't it give me immense pleasure?

[P: To hell with you! I'm not interested in giving you pleasure. I'd rather kill you first.]

Success! The aggressive impulse that was first attached to the patient's ego has been redirected toward the object; it becomes the target of a verbal attack.

The schizophrenic ego usually malfunctions because the primary object that influenced its formation failed to meet the infant's maturational needs. The analytic process may be viewed as one involving the removal of the defective internal object and replacing it with a good object.

The interpretation that the patient hated the parent at one time and now hates himself, however correct, would not remedy the situation. Correcting the defective functioning, and then understanding what caused it, is more constructive; it reduces the tendency to revert to the original pattern. The ego-modifying techniques just illustrated are directed toward that goal.

Ego-Syntonic Joining and Mirroring

Anna Freud's account (1926) of the initial phase of her treatment of a ten-year-old boy implicity conveys the spirit of ego-syntonic joining:

> At first, for a long time, I did nothing but follow his moods and humours along all their paths and bypaths. Did he come to his appointment in a cheerful disposition, I was cheerful too; if he were serious or depressed, I was the same. . . . I followed his lead in every subject of talk, from tales of pirates and questions of geography to stamp-collections and love stories. (p. 9)

Illustrations of agreeable joining and mirroring procedures follow. In some instances, it will be noted that the analyst gives positive directions by command or example.

Warm acquiescence. The analyst may associate himself verbally with a patient's negative views of members of his family, or mankind in general. For example, if the patients says that his parents are "impossible people," the therapists may express agreement. If the patient advances the opinion that analysts are no good, the rejoinder may be, "I agree with you. Even I'm no good at times." If he says again and again that the world is a ghastly place filled with revolting people, the analyst may say, "You're right. We're all going to hell!" [*Joining*]

The analyst may indulge in an emotional outburst against someone the patient is talking about. A student, reporting a mortifying experience, said that one of her instructors had ridiculed her before the whole class and denied her the opportunity to defend herself against his unfair criticism. The therapist exclaimed, "What a terrible instructor! He had absolutely no right to treat you that way." [*Joining*]

When a man leaving the office castigated himself for using the session for relief rather than work, the therapist remarked, "You have the right to waste an hour." "O.K. This is my wasted hour," the man said. He was told, "And I'm the bad analyst who permitted and helped you to waste it." [*Joining and mirroring*]

The analyst may respond with praise and encouragement when the patient refers to a desirable course of conduct or says that others are in the "same boat." If, for example, the patient clings to the idea that he needs a "good night's sleep," he may be told that the therapist also needs one. A student who reported attending a late party with his girlfriend was told, "She probably wants one, too." Later, the response to the communication may be, "A good night's sleep would do you a world of good." [*Ego-syntonic mirroring*]

Modeling new behavior. In applying himself to help the patient talk and act in harmony with his conscious wishes, the analyst may, directly or indirectly, model an appropriate pattern of behavior.

He may say, while reflecting the emotional attitude of a patient, "You feel like a pretty worthless human being."

[P: That's what I've been telling you.]

A: You shouldn't agree with me. You should tell me to keep quiet.

[P: That's right! You talk too much. You shouldn't say such things to me.]

A young man who repeatedly verbalized fantasies of cutting off his testicles and melodramatically offering them to his mother was asked if he would castrate himself for the analyst. The idea terrified him; he could say nothing. The analyst asked, "Why aren't you furious with me for asking that question? Any person who makes such a demand on you should be told to go to hell." The young man laughed uproariously for 5 minutes. The intervention resolved his preoccupation with terrifying castration fantasies (Spotnitz, 1961b, p. 36).

Helping the ego. Occasionally, when a patient repeatedly questions his ability to do something he feels would be in his best interests, the analyst may offer to help him or do it for him. (An intervention that would have the effect of silencing the patient, however, is out of order.) The analyst makes the kind of offer that will mobilize the patient to talk of making the effort himself.

A young man harboring misgivings about preparing for a career more or less mapped out for him felt unequal to discussing his own wishes in the matter with his father. The analyst asked, "Would you like me to talk to your father?" After the pros and cons of such an intercession were explored for several sessions, the patient decided to make the explanation himself.

MATURATIONAL INTERPRETATIONS

Obstacles to progressive communication are not conceptualized as ego defects. The analyst explains them in terms of cause and effect, as normal personality tendencies whose excessive development was inevitable in a special set of circumstances; no other alternative was possible. The patient who asks, for example, why he is so narcissistic may be told, "You were very

deprived early in life and developed problems that are difficult to deal with. As a result, you frequently become self-absorbed." The situation is explained in this ego-syntonic manner when the patient wants an interpretation and when, in the analyst's judgment, it will help the patient respond with additional feelings, thoughts, and memories. Eventually, the patient receives total explanations of the significant patterns of transference resistance.

The potentially therapeutic responses that the patient can make are those that contain his concealed impulses, feelings, thoughts, and memories (listed in the general order of their hierarchical organization in the mind). When verbalized, they carry with them a feeling of genuineness; the analyst recognizes that the patient has, at that moment, been totally honest.

Like Strachey's notion of the mutative interpretation (1934), the maturational interpretation is formulated to produce change, and it is formulated to effect that change with a minimum of suffering. It is acceptable to the patient because he does not feel that he is being attacked (Spotnitz, 1963).

It should be borne in mind, however, that whether an interpretation is maturational or not depends not only on the way it is presented but also on the setting and circumstances. For example, an interpretation that is acceptable and proves helpful to a patient in the one-to-one relationship may provoke injury or rage if given at an early stage of the group therapeutic situation, when the patient does not want the other members of the group to have any derogatory information about him. (An interpretation made in the group setting appears to have a more profound effect on the patient and to involve much more of the personality structure than in the dyad.)

Interpretations are presented in the same sequence as questions. The repetitive pattern is described first in terms of general experience, far removed from the patient's ego. Later, utilizing the evidence at his disposal, the analyst couches his explanations in terms of the family, the patient's own objects. Later the interpretation may be made in terms of the internalized object, and then in terms of the ego. In short, interpretations are given when the patient wants them, can assimilate them, and can use them constructively.

If, for example, the patient asks why he hates himself, the

analyst may point out that many people do so because in their childhood they preferred hating themselves to hating their parents. The feelings of self-hatred are then interpreted in the context of the patient's earliest interchanges with his own parents and other significant objects. Interpretations presented late in treatment may be dominated by the theme: You hate yourself because you hate the way you behave.

A patient with strong guilt feelings about masturbation may repeatedly ask whether he should give it up. The analyst does not convey either approval or disapproval. He may say that masturbation does give people pleasure because it eases sexual tensions; on the other hand, it tends to isolate them. Hence, while it may be desirable to limit such indulgence when one wants to be sociable, it is a good idea to masturbate more when one does not want to be sociable.

If the patient continues to bring up the subject, the therapist may tell him what other patients have reported about their masturbatory activity and their experiences in giving it up. Standard interpretations are provided later if the patient is really interested in understanding his own masturbatory urges.

Crying and other preverbal resistance patterns may be interpreted to a schizophrenic individual after it has been demonstrated that they are temporarily reversible. Until then, questions about the patterns are responded to with counterquestions and reflective interventions.

Sequence and Transference States

Narcissistic Transference (Early Stage)

A well-conducted analytic session is usually characterized by mild deprivation (to facilitate the release of the schizophrenic patient's aggressive impulses and feelings) followed by mild gratification later in the session. The defensive methods the patient utilizes to avoid discharging aggressive affects are psychologically mirrored by the analyst early in the session. Egosyntonic interventions preferably follow so that the patient may leave the office in a state of relative comfort. The interventions

should not be so positive as to discourage the patient from expressing negative feelings or from finding fault with the therapist. These are the general principles for conducting the sessions although they are not implemented consistently throughout the treatment.

Directions (usually issued as commands) and questions alternating with statements reflecting the patient's repetitive statements are the dominant types of interventions throughout this stage. The analyst, by asking a few questions of the patient who does not attempt to make contact during the sessions, educates him (by identification) to the idea that he may ask them; in the process, the analyst provides a disguised form of verbal feeding. The patient is told that talking freely on any subject is cooperative behavior; he is helped to articulate his disagreeable impulses, feelings, and thoughts.

Usually the patient becomes aware during this period of a host of feelings he does not want to experience. He may solicit help in changing those feelings so that he will constantly experience "good" feelings. Inasmuch as the therapist has the task of influencing the patient to verbalize *all* of his feelings, and *preferably the unwanted ones first*, there is apt to be a conflict early in treatment over the patient's desire to "feel good all the time."

A patient who repeatedly says that he is miserable may be told, "You have a right to be miserable." If he says he is very disturbed, the analyst may say, "You may feel disturbed as long as you are willing to report it. What is important is not the feeling itself but verbalizing it."

A patient who becomes restless and says he wants to get off the couch may first be asked why he feels that way; but if he becomes insistent, the analyst may inquire, "Why don't you get off the couch if you're so uncomfortable?" A patient who says he doesn't feel like talking may be told that he is supposed to talk whether he feels like it or not. If he complains that he is not being given any information, the therapist may ask, "Why should I?" or "Why don't I give you any information?" Answers to such questions are elicited and discussed to help the patient release hostility in graduated doses, thus reducing the danger that he will react explosively as his dissatisfaction with the treatment situation mounts. (Even when his objections are repeat-