PREVERBAL CONFLICTS

The preoedipal or preverbal patient's difficulties relate to maturational failures in the first years of life—in some cases, the first two years of life and possibly intrauterine life. The popular belief that intrauterine life is a paradise in which the fetus floats in amniotic fluid at body temperature, receiving the proper amount of stimulation, led to the belief that childbirth is equivalent to being cast out of paradise. And, indeed, Frederic LeBoyer (1973), a Canadian obstetrician, observed that most infants showed physical signs that they were unhappy to be born. But LeBoyer, dissatisfied, raised the following question:

Why, since prior to birth the infant is buffeted about in utera while the mother goes about her various activities for nine months, as the space to live in gradually becomes smaller and smaller until finally his size forces him to leave the uterus and the infant is squeezed down a canal accompanied by more buffeting, squeezing and tension-inducing sounds, why is it not a great relief to be born? What are we doing wrong, what is the environment doing wrong, to make the post-birth period such an unpleasant experience for the baby?

LeBoyer asked a number of other questions: What confronts the baby as he bursts forth into the new world? Bright lights shining down on him, hurting his eyes and skin. Then the umbilical cord is cut. He gasps for air until he is spanked, and the air rushes into his lungs for the first time—another terrifying experience. And finally, he is wrapped in a cloth, which feels unpleasant on his sensitive skin. On closer examination, LeBoyer asked what does the baby have to be pleased about?

As a result of his questions, LeBoyer began to improve the conditions for the newborn. He experimented with dim lights. He placed the infant on the mother's belly without cutting the umbilical cord and waited until breathing occurred naturally and became regular. Only then did he cut the umbilical cord and submerge the infant in a warm bath, massaging its head while holding it gently on his hand. He waited until the infant was relaxed, playfully kicking his feet, and smiling, before he wrapped it in cloth.

The moments of birth are a torment that condition the infant to fear the future—or, in language that we can understand, creates bundles of body tension. The damage that leads to the narcissistic disorders seemingly occurs either through our lack of understanding about the infant's needs or through our inability to cope with his demands; thus, we cannot provide him with the proper environment.

LeBoyer has taught us that when a patient comes to us suffering from preoedipal conflicts, we are confronted with a problem similar to the one he faced. If we can understand what it is between mother, child, and the environment that leads to maturity, then we should be able to provide the appropriate treatment environment in which to help our patients mature. The analyst must ask, how the environment has failed to provide this person with

what he needed to overcome his anxieties and destructive impulsiveness sufficiently to fulfill his own potential.

In *Project for a Scientific Psychology* (1899) and in the opening pages of *Beyond the Pleasure Principle* (1920), Freud emphasized that the infant's first efforts are directed toward keeping himself impulse-free—that is, the earliest structure is a reflex apparatus which carries sensory excitation to the motor path. Freud's economic and dynamic theories were an elaboration of the basic premise that the ebb and flow of excitation leads to the creation of symptoms, dreams, and verbal slips as indirect forms of discharge. He viewed early ego functions as learned ways of coping with infantile sources of excitation to escape from unpleasure. Seeking discharge of unpleasurable sensation led to primary process thinking.

Recently, Escalona (1974) reported her observations of what appeared to be conscious intent in three-week-old infants who, by touching a soft blanket, searched for the pleasurable tactual stimulation they had previously experienced. Evidently, the cognitive structure emerges to help the infant discharge his drives and differentiate between his perceptions of self and other. A person regresses to mnemic (early) traces of pleasure to discharge tension symbolically in a manner that at an earlier time was available for the discharge of libidinal and destructive impulses.

In his search for drive satisfaction, an infant may cling to the fantasy of a satisfying breast despite the

fact that no milk is forthcoming. When destructive drives are mobilized, libidinal energies are tied up in a struggle to process destructive urges. If the infant's aggressive energy is not redirected to the motor system and the cumulative tension in the mental system is too great, the structure may be overwhelmed.

The baby seeks pleasurable or tension-reducing experiences, primarily connected with bodily comforts. When he is frustrated and in a state of helpless rage, destructive impulses may flood the ego. If tension-reducing defenses fail, unpleasant affects resemble what in a later stage are experienced as helplessness, inadequacy, or hopelessness. We speak of the pre-object period of infant omnipotence when, it is assumed, a baby is unable to differentiate his own pre-ego feelings from the reality of others. In his omnipotent state the infant attempts to destroy the source of unpleasure but can only attack the internal visual memories of feeding—images that cannot provide the needed satisfaction.

Today we are confronted with an abundance of persons who combine the somatic and socially deviant modes of turning their aggression inward, methods that may not appear to be so obvious a self-attack. Combinations of the somatic and deviant reactions are often seen in alcoholics or drug addicts. The person who attacks himself with alcoholism, drug addiction, or in other ways turns against his physical being is using an early-learned weapon to protect the object and blame himself. Recovery is

more difficult in these cases because the illness itself provides secondary gains. Thus these patients must not only get in touch with the feelings warded off in depression and schizophrenia but give up the pleasure they gain from their activities. Only when a patient is able to control his impulses can treatment allow his feelings to come to full bloom in the transference. Then, despite the intensity of his feelings, he will be able to verbalize his destructive impulses rather than act on them.

THE SCHIZOPHRENIC REACTION

In other cases it is the mind that is attacked. The patient may say, "I am confused" or he may speak in a fragmented way as his cognitive functions—thought, judgment, perception—begin to deteriorate. When this happens, we speak of the schizophrenic reaction, in which relationships are protected at the sacrifice of contact with reality. Schizophrenia, an intricately structured but psychologically unsuccessful defense against destructive behavior, appears to be patterned during the undifferentiated phase of development when ego and object representations overlap.

In the conflict between aggressive wishes and the desire to preserve the object image, the cost is the destruction of feeling and thought processes. The individual is immobilized by this disintegration and loses touch with what he feels. Although this defense

has many secondary consequences, the three primary ones are aggression against the mental functioning, protection of the object field of the mind, and sacrifice of the self.

For patients who were severely deprived early in life, this response may have been the only means of regaining equilibrium. For example, infants sleep to block off external realities and avoid pain. The history of this defense can be described as follows: If a gratifying image has been replaced in the memory by an image of a depriving person, the desire to annihilate the bad image presumably follows. The orally regressed psyche clings to visual images of early figures with libidinal longing and obliterates them with aggressive destructiveness. In this case, the intrapsychic picture is one of libidinal, or positively charged energy used to defend against the negatively charged energy that creates the wish to destroy the object of libidinal attachment. The patient who uses withdrawal is likely to terminate treatment if he cannot through this withdrawal limit the amount of stimulation he receives. The patient who defends himself by destroying his mind usually does not want to establish an analytic relationship in which strong feelings for the analyst will be aroused. He wants treatment and may hope that he will be made comfortable in the analytic session. If he stays in treatment, he may hope that the analyst will tell him something that will enable him to leave and that everything will then be all right. But he certainly does not want to be emotionally involved in reexperi-

encing earlier frustrations and deprivations that will arouse fantasies of rage and annihilation and in turn arouse his fears of destructive action.

The link between the schizophrenic reaction and self-hatred is a rather recent psychiatric discovery. Over twenty years ago, it was commonly believed that the primary problem in narcissism was self-love. In treatment the schizophrenic was approached as a person who had withdrawn into a world of his own because he found the people in his real world unlovable. The notion that he was satisfied to love himself in this fantasy world seemed to account for the difficulty of persuading him to return to the world of reality.

Some practitioners still maintain this view of schizophrenia—they base treatment on the idea that the primary need of the patient who behaves this way is compensation in the analysis for earlier emotional deprivation, and that satisfaction of this need will help the patient love others and commit himself to a more sociable way of life.

Because the schizophrenic is an emotionally deprived individual, the analyst's impulse is to respond to his suffering with kindness. When starting out with the schizophrenic patient, many practitioners believe they should give him support, sympathy and encouragement. After listening hour after hour to the schizophrenic patient's descriptions of his strange feelings and the mysterious voices he hears, the analyst may become anxious and attempt to relieve himself of these feelings by trying to soothe the patient.

Experience has taught us, however, that this type of treatment does not help the schizophrenic recover. The schizophrenic patient responds to a sympathetic approach by developing a warmly positive attachment, and the more attached he becomes the more schizophrenic he becomes. In other words, his customary defenses become even more entrenched to guard against the release of hostility. It should be noted that this pattern of behavior is involuntary and compulsive, not deliberate. Few patients are aware that they bury their aggressive impulses or why they are doing so.

One of the earliest clues to this problem was discovered by Spotnitz during his residency in a psychiatric institution. His patient was an attractive young woman, a bride of several months, who was hospitalized following a psychotic episode. In her acute catatonic state, she blotted out her feelings. She did not even feel pain when a cigarette stub burned her fingers; the stubs had to be taken from her.

Several hours a day, five to seven days a week, Spotnitz listened to her sympathetically, tried to draw her out, and laughed with her at her own wisecracks. Nothing significant happened, however, until he said a few harsh words to her. She instantly responded by hurling a glass ashtray at him, missing his head by inches. The miss, she said later, was intentional; but she had really felt like killing him. Spotnitz helped her to accept the idea that she was entitled to vent her rage as often as she wished, provided that she exploded in feelings and words

instead of throwing things. At this point, the patient began to improve.

Eventually, it became clear that her initial psychotic episode had been precipitated by rage at her husband. About a month before the breakdown, she had undergone an abortion because she believed her husband had tricked her into an unwanted pregnancy. Extensive treatment in childhood and adolescence, combined with the fact that her illness was acute and recent rather than chronic, helped to account for her rapid progress in treatment. She was able to talk out her hostility within six months and was discharged from the hospital as recovered. We attribute her subsequent recovery to the fact that she stopped defending herself against her hatred and learned how to feel it and verbalize or release it in appropriate behavior.

Another clue to the basic problem was furnished by a schizophrenic woman whom Spotnitz treated some years ago. Her associates regarded her as a pleasant, placid person, who kept to herself. When she began to talk rather freely about herself, it was obvious that she was preoccupied with death. She often said that she felt dead. She could recall only one time in her life when she had felt really alive. While reading in her ground-floor apartment one day, she heard a thump outside. She went to the window to investigate and saw a man lying in the yard with blood trickling from his mouth. He had just jumped from the roof of the building and died in a matter of seconds as she watched. The sight electrified her: "I came to life the moment I saw death."

Clearly, this gentle woman labored under a strong urge to kill, which had been satisfied for the moment by seeing the man die. The feeling that she was dead herself protected her against this urge. In childhood, she had been trained to repress her bad-thoughts and feelings. When she discovered she could entertain the idea of killing, she tried to disown it, terrified at the thought she might yield to it. She was not aware that her mind wiped out these feelings; she simply knew that she felt out of things and not really alive. Thus, a sight that would horrify the average person vitalized her dramatically. When a person reacts as this woman did in an encounter with death, it often signified that he has an enormous amount of aggression to discharge.

"When I feel like killing you, I kill my feelings instead"; this is the gist of the statements that patients, men and women, often make in treatment when they begin to understand how they cope with their hostility toward the people who are important to them. For example, an analyst's inadvertent remark to a patient in her forties about the fact that she was middle-aged made her furious, but she was quiet for a few minutes. Then she said, "If I had not blotted you out of my mind just now, I would have gotten off this couch and killed you." As a child, she had blotted out her mother in the same way during outbursts of rage. Similarly, patients' feelings that the analyst is not in the room with them often serve a protective function.

The reluctance of schizophrenic patients to express hostility tends to increase when they are ex-

posed to sympathetic attitudes. On the other hand, when the analyst succeeds in communicating that he recognizes the patient's anxiety about behaving destructively in treatment, the patient is able to talk more spontaneously. It is impressive to observe the animated appearance of these patients after a session punctuated by angry verbal explosions. The periodic recurrence of these explosions after the patient has overcome his initial reluctance to disclose negative feelings suggests that internalized hatred builds up pressure that must be discharged from time to time. When these impulses are discharged in language, the symptoms of the illness tend to disappear.

These and other significant clues to the primary problem were found in the course of treatment of many schizophrenic patients. Considered singly, each observation contributed only a small piece of evidence; but together these clues formed a total picture of the illness.

The schizophrenic is a person who has placed himself in a psychological straightjacket to prevent himself from acting as his aggressive impulses tell him to act. Although he feels some love for others, his potential hatred is much greater, and he prefers to put himself out of commission psychologically rather than act on his strong aggressive impulses. Most likely he does not consciously recognize that he is sacrificing his own emotional health for the welfare of others. Nevertheless, he is at heart a socially minded human being who has developed a self-damaging way of controlling the destructive forces of his own mind

in order to protect the object field of his mind. As long as this defense is successful, he is not a threat to society. Only when it fails does he engage in suicidal or homicidal behavior.

If the situation just depicted could not be altered, we would have an extremely difficult choice to make: to help the patient continue to internalize his hostility at the risk of destroying himself or to help him externalize it at the risk of destroying others. Fortunately, there is now a solution to this moral and psychological dilemma. The schizophrenic reaction is reversible. The patient can learn to discharge his hostile impulses without harming others, and language is a powerful tool for accomplishing this discharge.

Perhaps it should be explained at this point that an unloving mother is not the sole or primary cause of the schizophrenic reaction. Although schizophrenia is not an inherited condition, some people are predisposed to it by genetic or constitutional factors. Moreover, even when the illness appears to originate in the mother-child relationship, the mother's attitude may not have been inappropriate. Whether she actually loved the infant, hated him, or was indifferent to him is less significant than the fact that the totality of his experience failed to meet his specific emotional needs and caused him to perceive his environment, on the whole, as an extremely frustrating one. In any case, the child's emotional reality is that he does not feel love. Let us assume that he correctly senses that his mother does not love him; in this situation, the

healthy assumption is that she lacks the capacity to do so. But the unloved child fights against admitting this to himself. He would rather believe that he is undeserving of his mother's love than that she is emotionally defective. Thus, the desirable attitude is distorted in the child's unconscious into the fiction that it is he who is defective—i.e., a bad child who is undeserving of love. If he can just stop hating, having bad thoughts, and misbehaving, he can make himself over into the kind of child his mother can love. In this way, he preserves the hope of receiving love.

In the extreme form of schizophrenic withdrawal, the patient regresses to a catatonic state in which early maternal images that were incorporated into his psychic structure objects of longing are warded off: that is, he strives neither to long for nor identify with them. For the moment, the intensity of his destructive impulses outweighs his libidinal impulses. But by using the available libidinal energy to immobilize himself, the catatonic prevents destructive action and, because of the amount of energy required to block action, is capable of only the most rudimentary form of identification—imitation. This level of incorporation apes the visual images of early infancy, actions to which no comprehensible meaning can be attached (Glover 1949, p. 83).

We know that the ability to identify requires less cathexis than does loving. All that identification requires is the perception in the mind's object field of an autoplastic representation, which can then be viewed as part of the self. Even less energy is needed

for imitation. The catatonic's longing for love is present in the gestures with which he apes others. In his physical stereotypes, we see that the hallucinated objects of his longing, combined with his attacks, are frozen into his posturings. By aping (incorporating or swallowing) the gestures of his therapist, he simultaneously destroys object impressions. Since the psychic system has lost its ability to integrate sensory impressions, this aping represents a simultaneous warding off and a longing for nurturance. The barrier the catatonic erects by freezing his body mimics the sightless babe at the breast who makes his body rigid as he refuses the nipple. The bad nipple image can only be annihilated by a regressive stiffening of the body, and the catatonic has regressed to this primitive state. A powerful description of the catatonic's withdrawal from life is provided by Paul Sayer in *The Comforts of Madness* (1990).

NARCISSISM IN MANIC-DEPRESSIVE, PARANOID, AND PHOBIC REACTIONS

To describe the depressive reaction, Weiss (1963) modified the popular psychoanalytic theory that the object was swallowed because it was given up, and returned to an earlier theory that the object was first internalized at the infantile level through sensory impressions connected with gratifying experiences and, when given up could not be shaken. "It clings like an echo," he wrote. This theoretical posi-

tion helps the analyst understand patient communications such as, "There is a parasite or usurper inside me," when they are accompanied by self-attack.

Unlike the schizophrenic, the depressive patient seems to cling to an internalized transference image with longing and hope while turning his attack against himself. He attacks his own worth to explain his deprivation. In his regression there may be some blurring of self-other images, which permits the self-attack to serve the function of object annihilation. The self-attack serves as a threat: If you mistreat me, I will punish you by depriving you of me. If you are like me, that will hurt you as much as your loss hurts me.

While the schizophrenic forgets his longings and obliterates his affects, the depressive maintains his resentment of internalized objects. He seems to hate his objects as an unshakable part of himself. Although he may be unable to relate with libido to the external person, he has enough energy to identify with the object impressions within from which he cannot shake loose. When the depressive person comes to treatment, he may say that he's worthless or hopeless or may portray himself as a disappointing person and insist that he should be thrown out of treatment. If he takes the paranoid position, he may be convinced that the analyst cannot stand him, but in either case, the patient attacks his own person by reacting with hopelessness, worthlessness, and helplessness. Paranoia and depression reflect the patient's confusion of self-impressions with object impressions. In paranoia

self-impressions as well as object impressions are externalized and in depression object impressions are confused with the self. We sense that the depressive attacks the internal images in an attempt to disown this "I" within that he wants to separate from his "real self." When he says, "I am worthless, I am hopeless," part of him is talking about the perceived internal other and trying to rid himself of it.

Schizophrenic and depressive patients, reliving those experiences that taught them how to destroy mind and self, present a preinterpretive problem. (See Postscript for new developments.) Paranoid patients struggle to avoid feelings of helplessness; generally, to avoid feeling humiliated and controlled, they project the self-deprecatory image onto a figure in the current environment. Nydes (1963) predicted that depressive patients with their self-accusatory style tended to become paranoid rather than manic, as predicted by early Freudian theory. Unlike the depressive who, by attacking himself, attacks the internalized images with which he is identified, a paranoid patient may eject the hostile image onto the external environment. In both paranoia and melancholia, we see the withdrawal of libido from hallucinated wish-fulfilling images.

In this pre-object period of weaker ego boundaries, it is a relatively small step for the person to eject the frustrating and critical impressions, experiencing them as intruders into the psyche. Weiss (1960) related the paranoid fear of being poisoned by the external object to the deep fear of reincorporating the

bad image and deeper desire to let it back in. He reported that regressed paranoid patients were afraid they would succumb to the deeper wish to reincorporate the object. When these patients were not protecting themselves from bad food or other substances that penetrate the body, or from sexual advances, they heard voices telling them what to do. In fact, voices may reoccupy the body. During a reintegration with the externalized part of the self, several patients described their minds as filled with invisible people who "are not me."

When the paranoid patient's mind is occupied in this way, the patient struggles against helpless rage and feels that matters are beyond his control. His impulses may be directed outward as he deals emotionally with the destructiveness perceived as belonging to the world outside his psyche.

In hypomania, the patient may perceive others as bad and, in the role of conquering hero, take "justifiable" aggressive action. Thus the destructive impulses of infancy are projected, allowing the self to remain identified with the critical object. By perceiving the bad self as being in the environment and by using aggressive impulses in an attack against the environment, the hypomanic maintains comfortable feelings about himself. If the manic can successfully sublimate his rage by becoming a fighter for causes, he can vent his wrath against external evils in a socially useful way. When an individual is able to channel his destructive urges into socially acceptable attacks on external situations, bad images no longer

remain in the ego field of his mind. Instead, with criticism turned outward, the self is not under attack from inside, as in depression, or from outside, as in some cases of paranoia. Destructive actions become possible as justifiable punishment for projected misdeeds.

Within the limits of this chapter, it would be difficult to do justice to the wide range of pathologies that can be understood as adaptations to the tension created by the patterns of frustration during the early months of life. In depersonalization, the patient gives up certain aspects of the self. Behind his conscious fear of loving, we may find rage about remembered deprivation, fear of destructive impulses, and fear of losing himself in regression. Anorexia and other somatic conditions remind us that the avenues of discharge available to the infant are limited by motor limitations during early tension-producing, prefeeling states.

CONCLUSION

The object field of the mind is a fantasy area in which a patient may perceive the bad or depriving images as part of the self or as alien from the self. In psychosis, the patient banishes the object image from his mind or confuses it with the self.

A number of patterns of self-attack are difficult to treat by traditional analytic techniques, and it is in relation to treatment of these patterns that modern

analysis is making significant inroads. When a person gives up his narcissistic defense, he may engage in self-destructive acts such as suicide or self-mutilation, or resort to homicide. The narcissistic defense breaks down when the amount of libidinal cathexis is insufficient to balance the aggressive drive. When the narcissistic defense fails and the aggression is turned against the environment, psychotic eruption is avoided if the patient can annihilate the memory image and related feelings by the process of externalizing to a current figure in the environment. Earlier, psychoanalysts linked these diagnostic categories with libido and repression of oedipal wishes (paranoia specifically with sexual inversion); today we seek to resolve patterns of self-attack.

No one theory is adequate to explain the behavior of all patients. From the emotional experiences we share with a particular patient, we learn how that patient structured his solutions to conflict. The energy constructs described here have been extremely helpful in understanding the infant's and the regressed adult's reactions to his drives. As the energy is used to integrate aural and visual impressions, echoing within the mental structure, sorting non-ego from ego and reality from fantasy requires a quantum of energy that is not available when tied up in warding off sensory impressions. This theory of internalization and externalization of early visual images conceptualizes the dynamics of the severe narcissistic disorders in economic terms. If the individual case determines the best theory to explain

it, we must ask: What are the advantages of developing theories to explain the psychic structure of our patients? In our work with patients, we find that as we begin to understand the patient's disguised communications, he is freed to develop his own understanding of his emotional life. Although our patients' understanding may be different from ours and our solutions may not be those they would choose, they seem to need our efforts and understanding. When their understanding is correct for them, they are able to change.

THE NARCISSISTIC TRANSFERENCE

Through its concern with the development of therapeutic responses to narcissistic patterns, modern psychoanalysis has opened the field of psychoanalysis to research and investigation into genetic, constitutional, and early environmental factors in personality development. But to develop a therapeutic response to the preverbal patient, it was necessary to explore what it meant to hide behind the narcissistic defense.

The narcissistic personality was poorly understood when these investigations began. The traditional view that the patient must have a sufficiently mature ego with which the analyst can establish a working alliance was abandoned when modern analysts became interested in studying persons with preoedipal, preverbal disorders to determine how they can be treated and their illnesses reversed.

Much of the modern analyst's time and attention has been devoted to the methods of treating narcis-

sism. To call modern psychoanalysis a new approach to narcissism seems fitting because it is in this area that the discipline has made its major contributions to the body of knowledge known as psychoanalysis. Working with individuals with fixations in the first year or two of life has led to the development of new techniques for the treatment of preverbal disorders.

The idea was new that analytic treatment of the preverbal patient could be based on Freud's concepts of transference and resistance and that, through transference, the patient could re-experience the traumas of the first two years of life as well as later verbal conflicts. Although traditional analysis had proved successful with the hysterias, the phobias, and the compulsions, Freud was unable to modify the interpretive approach to suit the treatment of narcissistic disorders. Despite the numerous clues he gave his colleagues in his dreams and other disguised communications, he never revealed directly the nature of his own preoedipal wishes. As a result, he was unable to deal with the feelings induced in him by paranoid or schizophrenic patients or by other preverbal regressions.

THE NARCISSISTIC DEFENSE

Spotnitz (1969) discovered that the analyst resolves the adult patient's repetitive self-attacks by changing the flow of destructive impulsivity. When the patient is frustrated, the appropriate way to

discharge his feelings is to put them into words. If he is prevented from doing so when frustrated and feeling deprived by the analyst, he usually bottles up the aggression: in other words, he turns these feelings inward and begins to attack the self. ***This is referred to as the narcissistic defense.***

To explain the patient's need to resort to the narcissistic defense, we think of the interpersonal patterns that created pre-ego, prefeeling patterns of discharge. In a regression to this emotional level of development predating language, the patient's communications return to the timeless world of infancy with its lack of temporal and spatial continuity and the inability to predict or anticipate events. When regressed, the narcissistic person does not seem able to distinguish between inner and outer reality. In the words of one patient who got in touch with this process: "I want to kill you to get you out of my head."

The analyst tries to keep in mind that when the patient brings the narcissistic defense into the transference relationship, he is doing it to protect the analyst from his hostility, as he did the mother image, by attacking himself. When a patient tells an analyst that the failures in the analysis are his own fault, not the analyst's, the analyst attempts to redirect the patient's self-attacks and the inward flow of destructiveness if possible. If the analyst provides the proper environment, the patient will re-experience emotional reactions in his relationship with the analyst that resemble those he had at some point in the past

when his maturation was blocked. To prevent motor discharge when old destructive impulses are aroused in the treatment, each patient returns to his own early adaptive modes, which in the context of the present situation may appear irrational. If the patient can relive that period with the analyst—that is, develop a transference—the analyst may be able to make the appropriate communications that will free the patient to mature.

The patient who is treated while regressed to the first years of life develops a narcissistic transference rather than an object transference. But analysts ask: "Do we want a narcissistic transference to develop?" We do because in a negative, regressed state, the patient may experience the analyst as being like him or part of him. Or the analyst may not exist for him. The syntonic feeling of oneness is a curative one, while the feeling of aloneness, the withdrawn state, is merely protective. Because traces of narcissism remain in everyone, we seek, when beginning treatment, to create an environment that will facilitate a narcissistic transference so that, first, we can work through the patient's narcissistic aggression. The extent to which the patient wards us off and avoids emotional contact tells us the degree to which he is narcissistically fixated. He will gradually increase his contacts with us if we create the appropriate environment. To establish the ego-syntonic atmosphere in which the patient can view us as being like him, or at least as non-threatening and nonjudgmental, modern analysts carefully avoid exposing the patient to any uninvited communication or interpretation. When

the patient feels that he can say and feel things without taking action, his emotional contacts with the analyst will increase. Bringing out whatever narcissism remains in the personality helps the person who has a minimum amount of narcissistic defensiveness to remain in treatment when his impulsiveness surfaces. By not providing the patient with excessive communication, the analyst can maintain the ego-syntonic environment necessary to master his patient's destructive impulses.

Unfortunately, it is difficult for the analyst to remain objective when the patient expresses a narcissistic transference, or later when he attacks unceasingly the analyst's faults, pinpointing the sensitive spots in the analyst's personality and treatment methods. If the patient announces that he is destroying himself, has done terrible things to himself, and is not finished being self-destructive, the analyst's defenses are usually aroused against induced feelings of hopelessness, isolation, or rage. It is easier to put distance between himself and this unpleasant, provocative patient by thinking, "Poor fellow, he needs my help. Perhaps I should be supportive or gratifying to the patient." But this approach leads the patient to attack himself even more and increases the analyst's feeling of hopelessness.

NARCISSISM IN A PHOBIC CASE

The following case, reported by Meadow, revealed a pattern in which a patient who had lived

most of her life behind the manic defense, developed a thin disguise for her narcissism in phobic symptomatology. Barbara presented an interesting combination of phobias and hypomanic defenses used to deal with intolerance of negative affects. Using the manic defense, this patient externalized her badness and was able to turn her destructive impulses against the environment. This enabled her to maintain a relatively comfortable internal state.

Barbara worked as an executive in a large male-dominated firm and devoted enormous amounts of energy to the fight for women's rights. These efforts kept her relatively symptom-free for years. Later, she was an active crusader against injustice. These crusades were a further attempt at stabilization. Eventually, however, because these activities did not satisfy her desire for revenge against the original parent figures, Barbara became more concerned with the evil around her. Her need to distort events into black and white issues intensified the good/bad split, which took on paranoid overtones. Previous therapy had not successfully integrated these good and bad images and the split had occurred when her former therapist, appearing unethical to Barbara, necessitated further defensive measures.

Between the time her first treatment ended and the second began, Barbara's phobic symptomatology appeared. The phobias served to limit her social contacts and apparently protected her from a desire to act on her destructive impulses. The price she paid was to remain in suspended animation and a double

bind. Her longing to be close to others and to be with a much admired person aroused fears that she would lose the protective barrier against past feelings and led to the symptom of agoraphobia, which kept her reclusive. When she did allow herself to approach a personal relationship, she experienced a strong desire to get away from the person and be liberated from the critical feelings that emerged. This resulted in the symptom of claustrophobia.

Barbara considered herself to be an independent woman and felt disdain for her female friends who tolerated unhappy marriages. She would rather be free to enjoy herself than be married; she could sleep as long as she wished, soak in a warm tub as long as she wanted, and have sexual relations when and with whom she wanted, according to her mood. She did not have to "submit" as her married friends did, and best of all, she could avoid the constant bickering that her married friends considered normal. She also enjoyed being free to go wherever and whenever she pleased.

This patient could not tolerate tight-fitting clothing. She had difficulty finding dresses that were bearable; belts were an impossible restriction. She preferred the kind of dress that one can forget about.

In a group, Barbara usually felt tense—as if everyone was "on top of her." Although she did not like to ride in a car too long with another person, long drives alone were tolerable. When she entered treatment for the second time, one of her presenting symptoms was a fear of elevators. The analyst's first

impression was that she was suffering from a phobic reaction—that her symptoms served to ward off feelings of helplessness and dependency—and her basic struggle was to rid herself of attachments that created these feelings. Her history revealed that the desire to rid herself of longings was in the service of object protection. Her claustrophobia, panic about tight-fitting clothing, and fear of small crowded rooms, elevators, and the intensity of marital relations protected her from the narcissistic defense as it is manifested in schizophrenia. She wanted to be free, but the message of her agoraphobia was "I do not want the freedom that I consciously crave; I *want* to be tied to people, but I cannot tolerate the feelings."

Analysts have written extensively about the oedipal conflicts expressed in the phobia, so these conflicts will not be detailed here. In fact, these conflicts were not significant in Barbara's case. Fear of circumscribed events and objects (the phobic reaction), provided adequate protection against total emotional withdrawal, allowing some fluctuations and conflict. A modern psychoanalyst would not attempt to disrupt this defense until the underlying aggression could be discharged sufficiently.

The removal of Barbara's phobias at the point described here could predictably lead to a more severe regression. Treatment in such cases entails the development of a narcissistic transference in which the patient can be presented with a faithful twin image.

As treatment progressed, Barbara continued to

present her fears. She was concerned with her fear of enclosed and open spaces. Her phobias served precisely the same function that withdrawal serves, but they allowed her to preserve the perceptual and cognitive functions. Rage, not sexuality, was to be avoided. So long as the therapist kept her distance, Barbara did not fear the couch, and by focusing on the content of her phobias and her life, she avoided real closeness during the sessions. When she was tottering on the narrow divide between her fear of closed and open spaces, what surfaced in the session was that being liberated meant freedom from the feelings that relationships aroused in her, and particularly the feeling of helpless rage. In the transference, she revealed her desire to annihilate anyone who aroused in her longings for emotional closeness. Longings made her feel weak, inadequate and helpless. The phobic anxiety was a reaction to reemerging feelings. But loss of closeness aroused the counter phobia that she would find herself in an objectless world; at that point, she wanted to return to closed-in places and to some contact with people. The claustrophobic response appeared when people were overstimulating. Clearly, Barbara was symbolically asking: "Should I enter human relations, get involved, and suffer all the pain of hostile feelings, or should I keep myself safe?"

Barbara arranged her social life so that her male friends appeared on demand. She had a list of three or four current boyfriends, and when she wanted a sexual relationship, she telephoned one of them.

On the oedipal level, Barbara's sexual arrangements and fear of her sexuality can be considered a compromise, but we are concerned here with the nurturing conflict. Barbara was drawn to a potentially nurturing situation, but she protected herself from it by demeaning the object. The men in her life served two purposes: providing intimate relationships without intimacy and the freedom to back off when closeness threatened. In other words, these men provided partial relationships. Barbara thought of all people, male and female, as mother figures: i.e., her relationships were preoedipal. The phobias served to provide her with controlled mothering that was similar to the infant's desire to have its mother on call to provide services. The phobia's deepest disguised message, however, was infantile longing and the wish to destroy or incorporate the object as it was perceived during Barbara's first year of life.

Barbara's first adjustment was a mania that worked for her. Later she created phobias that also worked. The symbiotic struggle between self and introject is seen in alternating states of claustrophobia and agoraphobia in which the fear of losing the needed images oscillated with the wish to destroy the unsatisfying image. When her fear of destructive impulses dominated, Barbara became claustrophobic. This type of patient may consciously experience an internal restriction (the counterforce) on the somatic level and express thoughts of the wish for unrestricted freedom.

Phobias are common enough symptoms in

mental hospitals, where we find patients who rip off their clothes or are unable to leave a room or a particular area. These symptoms often appear as part of the schizophrenic picture.

In cases such as Barbara's, the determining factor in the symptomatology and how the patient will play out his interpersonal relations is a result of the way he visualizes the early maternal environment and his feelings about the quality of mothering he received. As he learns to give up old pathways of discharge and differentiate between the self and other, he discovers the rewards of personal relationships.

CONCLUSION

The psyche of the preverbal patient contains a strong libidinal attachment to others and a strong desire for the warmth and closeness that others can provide. This is the kind of closeness one expects during the first year of life—to be held, to be walked, to be rocked, to be talked to, and in general to be soothed. It is these longings that are reactivated in the narcissistic transference. In fact, these longings help the patient decide to protect the significant persons in his life. When he becomes murderously enraged, because of frustration, all that stands between him and his impulses are his libidinal feelings for his mother. In the treatment relationship, the analyst eventually becomes the person with whom the patient must work out and resolve his emotional prob-