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Cases Presented by Kohut's Followers

Psychology of the Self and the Treatment of Narcissism

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Cases Presented by Kohut's Followers

During his lifetime Kohut's followers began making changes in Kohut's conceptions of certain psychiatric diagnoses and of psychoanalytic psychotherapy. In some instances these changes were an improvement, but in others they made the psychology of the self more ambiguous and difficult to understand.

"The Casebook"—Gedo's Criticism

An important collection of case presentations by Kohut's followers—young analysts who worked under his supervision—comprises the *Psychology of the Self: A Casebook* (Goldberg 1978). This collection is examined by Gedo (1980), a psychoanalyst from the same institute as Kohut who differs from Kohut in several important respects. Gedo reports, "We have witnessed the formation of hostile ideological camps engaging in global condemnation of or cultish enthusiasm for Kohut's 'system'" (pp. 363-364). Gedo asks to what extent the case reports can be used to support or refute the hypotheses of the psychology of the self.

Gedo believes that the cases make possible an operational

definition of fragmentation of the self in the broader sense of the term. The use of the self as a supraordinate psychological organization rather than as the representation of a concrete person appears prior to Kohut in other works cited by Gedo. He believes that the clinical material of the casebook is organized according to Kohut's hypotheses and is therefore unsuitable for testing them. However, Gedo underemphasizes the significance of a quotation from the casebook: "I was unable to 'hear' the significance of what the patient was saying until I had the conceptual assistance of a new analytic discovery" (p. 203). This acknowledgment from one of the analysts in the casebook is analogous to the point of Kohut's (1979) report on Mr. Z. and separates the psychoanalytic psychology of the self from numerous other theoretical orientations which are unlike those of Freud.

Kohut's followers contend that immersion in the psychology of the self enables the therapist to find significant themes in patient material that could not be noted without the assistance of Kohut's psychology of the self. The sudden coherence of hitherto apparently irrational material often causes the psychology of the self to have a dramatic impact even on an experienced psychotherapist. Gedo's argument that at least half of the case reports could be criticized as

being “flawed as models for the natural unfolding of the analytic transference” (p. 371) is reasonable; he reminds us that only the cases of Mr. E. and Mrs. R. were essentially complete “and beyond reasonable criticism in terms of technique” (p. 371).

Gedo questions whether repair of a developmental deficit occurs through transmuting internalization. More seriously, he argues with Goldberg that the “Goldberg casebook does not confirm his claim that ‘the activity of the analyst is *interpretation* (p. 9)” (p. 379). Gedo and others have criticized the tendency of Kohut and his followers to explain perverse behavior as the eroticization of other psychological needs or wishes. For example, it is not clear to Gedo (p. 381) why a fantasy of incorporating masculine power through fellatio should be sexually exciting as in the case reported by Kohut (1977, p. 201).

The final criticism concerns Kohut’s view of empathy, which the authors in the casebook now regard not only as a tool of observation but as an agent of healing. Gedo calls this an “idiosyncratic view of empathy as a quality of *behavior* that should characterize the conduct of the analyst” (pp. 381-382).

“The Casebook” Reviewed

The casebook was written in response to a persistent request from many clinicians for more clinical data, and Kohut’s followers have been energetic and dedicated to producing material for study. None of the six cases are thought to be borderline in Kohut’s sense of the definition. The introduction states that a group of psychoanalysts met, discussed this material, and that “there was, rather, a general impression that each of the patients had benefited enormously and that the classical clinical theory of psychoanalysis had little to offer in understanding these changes” (p. 3). A general idea of the goal of treatment is given:

> Results of successful working-through are indicated by an accretion of drive-controlling and drive-channeling structures, by idealization of the superego through diminution of the idealizing transference, and by integration of the grandiose fantasies into reasonable ambitions and purposes. (p. 8)

Unfolding narcissistic transferences are not viewed as defenses against the unfolding of object-instinctual transferences, i.e., not as “defense-transferences” (p. 14), but as indications of the beginning mobilization of archaic narcissistic configurations, which must be

allowed to move into and occupy the center stage of the analysis. For example (p. 115), Mr. I. attached himself to the analyst with an intense, addiction-like quality because he had serious difficulty in maintaining his own narcissistic equilibrium. Either there was too much inner tension with a feeling of overstimulation requiring immediate, frantic, and uncontrollable discharge or too little of it, reflected by a feeling of emptiness that required immediate and frantic self-stimulation. This is also a typical and instructive situation among cases in intensive psychotherapy.

The case of Mr. M. described by Kohut (1977) is given in detail in the casebook. Here, there seems to be an answer to Gedo’s complaint that there is no explanation of the erotization in perversions if they are thought of as the expression of other needs:

> In childhood, as well as in later life, perverse fantasies and activities appear to serve the defensive function of turning a painful affect that was passively endured in childhood through erotization into a sense of active mastery. While the sexual context affords the sense of mastery over the painful affect, it also provides a discharge channel for narcissistic tensions whether these were aroused from frustration or from overstimulation. (p. 136)

In the casebook there is little theoretical discussion of Kohut's idea that the sexual drives represent disintegration products of a fragmenting self after empathic failure. The casebook appeared not long after *The Restoration of the Self* and is written more along the lines of the "psychology of the self in the narrow sense."

A common clinical problem reported (p. 157) in the case of Mr. M. appears behind the disintegration of many marriages. Mr. M. was unable to be empathic with his wife who was an aspiring artist, and he could not give her the encouragement she needed. In a woman's attempt to achieve liberation, a career, and a healthy self of her own, the functioning of the husband as a reciprocal self-object is vital. In the case of Mr. M., he was too needy to have known what she needed from him and from their marriage, and so, the marriage failed. Kohut's (1984) emphasis on the importance of reciprocal mutual self-object functioning and empathy in a marriage is valuable in understanding the apparent tragic disintegration of many marriages as the needs of the partners change.

Chapter 4 of the casebook presents a difficult patient (Mrs. Apple) who might well be thought of as borderline from the standard

DSM-III diagnostic point of view. Mrs. Apple had been treated by a dedicated woman analyst. The case almost stalemated with the patient in a tremendous rage, but the analyst approached Kohut in an informal discussion, and attended his seminar. She was able to examine the patient's material in a new way.

Mrs. Apple's analyst mentions three possibilities which could explain the painful analytic situation: the patient's insistence on direct cure does not represent "resistance" to the re-exposure of childhood rage toward the oedipal and preoedipal mother but involves instead the analyst experienced as an archaic self-object; when the self-object analyst is uncertain about the nature of the original disorder and the transference, the analyst is experienced by the patient as the self-absorbed mother who spitefully refuses to respond to her, with all the rage and disappointment that entails in the patient; and the bombardment by the patient's narcissistic rage evokes an emotional withdrawal on the part of the analyst which further exacerbates the rage in a vicious cycle. Thus the return of childhood structural conflicts is not at the center of these disorders. The insistent demands are part of a mirror transference which, when misunderstood, represents another chronic exposure to an apparently unavailable and unwilling

self-object, with the expectable consequence of narcissistic rage in the patient. The analyst reports (p. 231) that, when reconstructions were made on the basis of this approach, there was a dramatic alteration of the patient's mood and state; this apparent "calming down" after an explanation of what is perceived by the patient as empathic failure is a common clinical finding.

The report on Mrs. R. in Chapter 6 is an example of how a small item in the treatment can be blown up into a major stumbling block because it condenses into one complaint the patient's disappointment in a number of minor empathic failures by the self-object analyst. The patient could not accept the analyst's insistence on calling her Mrs. R. rather than by her first name. In his long discussion we can sense that this sensitive analyst struggled about what should have been done. At the time he decided not to call her by her first name, but now he apologizes, for it is possible that by doing so he might have avoided an iatrogenic regression.

This is an example of Kohut's "reluctant compliance," which the analyst tries to distinguish from a parameter in Eissler's (1953) sense of the term and from the traditional emphasis on the "barrier"

(Tarachow 1963) that is presumably required between analyst and patient. The dispute is over whether “reluctant compliance” represents a “collusion” (Langs 1982) that avoids the rage or whether the lack of it represents an unempathic response to the patient. This is one of the more difficult clinical judgments every therapist has to make. The decision is affected by acceptance or rejection of self-psychology and by the countertransference implications.

The problem of *mea culpa* also arises in this case and illustrates the danger of the possible misuse of self-psychology to blame all the problems of the patient on failures in the therapist. The analyst did not telephone the patient from an international trip and display a hoped-for magical knowledge of when the patient’s child was born. The analyst felt, however, that he should have made a “special effort” to contact the patient close to her expected delivery date, “not simply as a compliance to regressively distorted demands, but as a concrete, needed acknowledgment of, and the providing of, an appropriate analytic atmosphere for her massively intensified needs” (p. 341). This attitude can lead to dangerous acting out on the part of the analyst and an infantilization of the patient; I (1983b) have given an example of this problem in my discussion of Greenson’s psychoanalytic therapy

with Marilyn Monroe. There is much room to argue about what constitutes the proper analytic atmosphere. In this instance the patient made substantial gains from serious pathology; it is also clear in all the cases presented that the analysts were caring and dedicated.

The final case is probably the most controversial, to the point of whether it constitutes an analysis. The therapist did some active mirroring in complying with the patient's request to view his new car (a used jeep): "I admired it, and he was pleased" (p. 387). A great deal of this sort of mirroring occurs in the privacy of the consulting room and not much of it is reported in the literature. The author of this case reports such incidents with great candor. She lends the patient money (p. 399) twice, although she does so reluctantly the second time (p. 404). In many ways this case history employs a psychoanalytic technique almost diametrically opposed to the recommendations of Langs (1981, 1982), which limit the activity of the analyst strictly to interpretations.

This case report provides an opportunity to study whether self-psychology offers the patient a "corrective emotional experience" or a genuine analysis. At best the analysis was incomplete, but more

mature transference wishes and attitudes did appear, indicating a significant gain in self-cohesion. However, this gain could have come about by either an analysis or a corrective emotional experience. One will have to decide whether the extent of the gain is best explained by transmuting internalizations and the consequent formation of compensatory structures or whether the improvement in self-cohesion occurred primarily through a corrective emotional experience supplied by the therapist.

An additional argument about the perversions is offered in the conclusion to the casebook, where these eroticized behaviors were found to be precipitated by the vicissitudes of relationships involving narcissistic transferences and disappointments in demanded self-object experiences. These narcissistic transferences were not difficult to discern and disruption of them most commonly appeared in the psychoanalysis through disconcerting symptoms on weekends, which would be much harder to detect in less frequent psychotherapy.

The cases were conducted under Kohut's supervision: "Now, having an enlarged schema for understanding what patients are saying, the analyst's potential for narcissistic injury is not stirred up

nearly as readily" (pp. 444-445). Clinicians attempting to evaluate the psychology of the self should keep this in mind to see whether they have similar experiences in better understanding difficult or unreasonable patients. None of this clinical material demonstrates the scientific validity of the hypotheses of the psychology of the self.

Borderline States Viewed by Self Psychologists

A more extreme use of the psychology of the self can be found in reports by the followers of Kohut who have attempted to modify his rather pessimistic view on the borderline states defined as "permanent or protracted breakup, enfeeblement, or serious distortion of the self, which is covered by more or less effective defensive structures" (Kohut 1977, p. 192). This seems to represent a long-term condition and to relate the borderline state to the paranoid and the schizoid personalities, who are attempting by defensive organizations employing distancing to prevent a similar permanent or protracted breakup, enfeeblement, or serious distortion of the self.

Tolpin (Goldberg 1980) discusses the "makeup and analyzability" of the borderline patient. According to Tolpin, Kohut maintains that,

although borderline patients are able to establish varying degrees of rapport with the analyst, the core sector of the self does not enter into transference amalgamations with the image of the analyst. Therefore, no stable self-object transferences can form. These archaic transferences are not allowed to develop because of the patient's fearful anticipation of a massive disruption. Without such in-depth transferences, proper transmuting internalizations cannot effect any basic change in the self.

For Kohut the borderline disturbance is always marked by a potential for protracted disturbance of the cohesiveness of the self, whereas the narcissistic personality disorder shows only a transient disturbance, a temporary breakup, enfeeblement, or distortion of the self at times of serious experienced self-object failure. In the psychotic patient, there are not even the organized defensive capabilities of the borderline person. However, in some psychotic individuals, such as the paranoid patient, cohesively organized sectors of the personality may parallel the core psychotic organization. An apparently normal social facade can even be maintained. This explains the clinical confusion between patients with a manifestly psychotic core and patients with a borderline personality who have more effective defensive structures,

but are more overtly disruptive.

The argument about the treatment of the final case in the casebook rests on the issue of whether a workable in-depth transference or series of transferences actually developed in the treatment. If so, one may say that the patient underwent at least a partial psychoanalysis. If not, the explanation of the patient's marked improvement would have to be explained by Tolpin's (Goldberg 1980) statement:

> Nonetheless, a meaningful rapport with the therapist may be fostered in relation to nonpsychotic personality sectors through the use of a variety of ingenious psychotherapeutic strategies, and these efforts will result in consequent strengthening and greater dominance of these nonpsychotic personality sectors, (p. 304)

Tolpin's Classification

Tolpin makes an effort within the self-psychology framework to bridge the gap between "unanalyzable" borderline disorders and "analyzable" narcissistic disorders. He suggests that there is a group of borderline disorders which form "the 'border' of the true borderline personality" (p. 306)—the "border" borderline personalities.

Somehow "despite the more blatant social maladjustments that may occur, the individual in this group has a self that is better organized than the self of the true borderline patient" (p. 307). Some members of this group develop massive, almost unmanageable, sometimes highly eroticized merger transferences (Chessick 1974b). As Tolpin says, such transferences "may severely tax the understanding, equanimity, and effectiveness of the therapist" (p. 307).

Tolpin suggests a spectrum concept based on the quality of the structure of the self, ranging from the healthy to the near-psychotic personality organization. The spectrum concept dictates that various disorders cannot be differentiated from a brief examination. Criteria for the diagnosis of disorders do not necessarily lie in behavior, symptoms, or the form of the disease—its manifest content or its social severity. Instead, diagnosis arises out of a prolonged evaluation or test of treatment which gives sufficient time for the development of adequate transference clues. In these cases the personality and empathic limitations of the therapist play a significant role in the assessment of the patient's primary core disturbance: "The assessment is at least in part based on the interaction of two participants in an extended diagnostic or treatment process. It is a

process that operates within a two-party system and the therapist may be as important a variable as the patient” (p. 308).

Tolpin gives an important clue: “The essence of a core psychotic personality organization,” whether defended against, as in the true borderline patient, or not, as in the psychotic patient, lies in the “extremely limited viability of positively toned primary self-object experiences” (p. 311). For a nonpsychotic personality organization, including Tolpin’s “border” borderline patients, there have to have been some viable, self-nourishing, attuned self-object experiences from infancy and childhood to provide a beginning for therapeutic rehabilitation of these severe disorders of the self. This allows the formation of what Kohut (1984, p. 206) calls a “pivotal” self-object transference, based on the least traumatic childhood self-object experiences, that can lead in treatment to the strengthening of crucial compensatory areas of the self. In taking a history one searches for memories and patterns of experiences involving significant adults who were entrusted with the care of the infant and young child. Sometimes a maid or a grandparent has provided the crucial spark in the otherwise dark ambience of the patient’s childhood.

However, we can be easily misled by taking a history; for this reason I (1974) suggest that all patients be given a trial of intensive uncovering psychotherapy when there is any possibility that they may benefit from it. This is preferable to flatly rejecting the use of this procedure on the basis of a DSM-III clinical diagnosis. Tolpin emphasizes the perseverance of the therapist and the empathy and sensitivity of the therapist; the less we understand a patient, the more we are prone to call the patient borderline. The talents and the empathy of the analyst are crucial. With such patients, vitality-producing empathic responses are desperately needed, sometimes for a very long time. Kohut (1984, pp. 182-184) makes the same point, referring to the concept of borderline pathology as relative, often depending on the analyst's ability to retain empathy despite repeated narcissistic wounding by the patient and to enable the patient, through the understanding of the patient's experiences, "to reassemble his or her self sufficiently with the aid of the self-object transference to make possible the gradual exploration of the dynamic and genetic causes of the underlying vulnerability" (p. 184).

The unresolved theoretical and clinical questions revolve around whether borderline patients can be helped to develop a cohesive self

—at least sufficiently cohesive to form relatively stable self-object transferences—and to what extent this is a function of the personal style, empathic capacities, and sensitivities of the therapist. My own clinical experience supports Tolpin's approach. A point of view firmly based on self-psychology, which is also corroborated by the clinical experience of intuitive investigators who practiced before the codification of self-psychology, constitutes further evidence for the validity or clinical efficacy of the psychology of the self. Many clinicians, on first acquaintance with Kohut's views, may have an "a-ha!" experience when they are thus given some theoretical understanding for what intuitive therapists already have been doing for some time. Traditional psychoanalysts would retort that what is new in self-psychology is not good and what is good is not new.

TOLPIN'S CASE REPORT

In a subsequent publication, Tolpin (1983) presents a detailed case of what might be called a pseudo-oedipal neurosis treated from the point of view of self-psychology. The patient, a divorced woman in her early forties, sought treatment for recurrent depressive states, insomnia, overuse of sleeping medication, and occasional kleptomania.

Her biggest problem, however, was a love affair with an older man who could not bring himself to marry her. On the surface the case appeared to be that of a histrionic personality disorder, but these symptoms, argues Tolpin, actually covered primary deficits in the patient's self and defended her against re-experiencing the effects of the disappointment in her early childhood self-object needs. In the dream material and in the use of Beethoven's Quartet, Opus 130,[1] the patient made a gradual substitution in which she internalized the idealized analyst. This resulted in an increased concept of her own self-worth and repaired a deficit in the self so that the patient no longer needed an outside idealized figure in order to maintain her self-esteem.

Self-psychology enabled Tolpin to recognize the patient's primary needs and to define these to her so that the elaborate histrionic symptomatology which defended her—what Tolpin calls "a complex and overdetermined defensive facade" (p. 480)—could be reduced via "the development and transformation of an idealizing transference" (p. 480). The clinical material depicts this development and transformation which were dominant in the treatment, although a variety of mirror transferences also appeared.

Brandchaft and Stolorow on Borderline States

Brandchaft and Stolorow (Lichtenberg, Bornstein, and Silver 1984a) carry this discussion of the borderline state further. They reject the idea that "borderline" refers to a discrete pathological character structure. DSM-III recognizes it as a diagnostic entity stressing impulsivity, intense unstable relationships, inappropriate anger, and mood swings, with additional reference to their physically self-damaging behavior, complaints of emptiness or boredom, and intolerance of being alone. Kernberg (1975) suggests that the borderline personality organization has a specific structure with splitting as the major defense. He carefully differentiates psychotic patients from borderline patients on the basis of their capacity for reality testing; in borderline patients, reality testing is seen as intact and only transiently blurred when the patient is under severe stress.

Utilizing the psychology of the self, Brandchaft and Stolorow have not suggested that the term "borderline" refers to an entirely iatrogenic illness, but rather that the patient's manifest psychopathology which leads to the diagnosis "is always *codetermined* by the patient's self-disorder *and* the therapist's ability to understand

it” (p. 367). They claim therefore (in direct opposition to Kernberg) that the concept of borderline personality organization is invalid and that borderline character structure is not rooted in any pathognomonic conflicts or defenses. To insist that “borderline personality organization” denotes a specific type of characterologic organization represents a misunderstanding on the part of therapists and “the difficulty therapists have in comprehending the archaic intersubjective contexts in which borderline pathology arises” (pp. 367-368).

Clinically, minor empathic failures of the self-object therapist as they are subjectively experienced by the patient—*not* to be used as an objective index of the therapist’s technical competence—are crucial to the production of borderline symptomatology. These empathic failures are experienced within the psychic reality of the patient from the archaic frame of reference created by the self-object transference. When the patient’s intrapsychic experiences and convictions come from a subjective point of view of the empathic failure of the therapist and are chronically unrecognized, DSM-III borderline phenomena displayed by the patient become chronic. The patient is then labeled a borderline personality disorder.

These authors also warn therapists against blaming themselves for psychopathological symptomatology that may appear in the treatment. In focusing on the empathic failures of the therapist as they are experienced by the patient, there is a tendency among followers of self-psychology to ignore that this occurs in the context of an archaic self-object transference which is bound to produce disappointments in the self-object. Kohut (1984) maintained that, if there is a reasonableness in the ambience of the treatment and the therapist has the capacity to recognize that the therapist has been experienced as producing an empathic failure and communicates this recognition to the patient, a situation arises which produces "optimal frustration." By transmuting internalization patients can gradually learn to do for themselves what they want the therapist to do for them in the self-object transference. A misunderstanding of this is a common beginner's mistake in the application of the psychology of the self and leads easily to much unnecessary self-castigation.

Brandchaft and Stolorow point out that when the needs of the "borderline" patient are not

> recognized, responded to, or interpreted empathically, violent negative reactions may ensue. If these angry

> reactions are presumed to represent a defensive dissociation of good and bad aspects of objects, this in effect constitutes a covert demand that the patient ignore his own subjective experiences and appreciate the "goodness" of the analyst and his interpretations. It precludes analysis of the patient's subjective experience in depth, (p. 335)

By reverting to concepts of projection and projective identification, the therapist deprives patients of a way of marking those instances where they feel the therapist is being cruel, distant, controlling, or demeaning. (Explanations utilizing projection and projective identification encourage the assumption of the analyst's goodness and correctness.) This can actually lead to a dangerous double-bind situation that resembles patients' experiences with parents.

Following Tolpin, these authors agree that at least in some borderline personalities it is possible for the patient to eventually form stable and analyzable self-object transferences although it is true that these are more primitive and intense, more labile and vulnerable to disruption, and much harder on the therapist. But these patients do not, if properly understood, develop severe chronic protracted break-ups of the self, because patients often will leave treatment before allowing such a break-up to occur (Chessick 1977, 1983a).

The borderline symptomatology is increased when there is a misunderstanding of what has exacerbated it, but I think Brandchaft and Stolorow are too sanguine in their hope that many borderline patients could eventually be analyzed. Kohut is quoted (p. 344) as telling them that to whatever extent the therapist is able to build an empathic bridge to the patient, the patient is no longer a borderline case but is now one of a severe narcissistic personality disorder. Borderline personality organization is not seen by self-psychologists as representing a fixed entity with characteristic defenses such as splitting, but as a fluid situation within an intersubjective field. An example of this is the case of "Carolyn" presented by Brandchaft and Stolorow (in Lichtenberg et al. 1984a).

In another publication (Stepansky and Goldberg 1984), Brandchaft and Stolorow offer more clinical material from the standpoint of the psychology of the self. They argue that the self-object theory of development "is a contemporary theory of object relations. It concerns the most archaic relationships to objects experienced as part of the self, merged with the self, or in the service of the self' (p. 108). This should be differentiated from the object-relations theories based on the work of Melanie Klein and carried forward by many other

authors such as Kernberg. Here Brandchaft and Stolorow contend that the excessive pregenital aggression of borderline patients is “the inevitable, unwitting consequence of a therapeutic approach which insists that certain arrested archaic needs and the archaic states of mind associated with them are in their essence pathological defenses against dependency on or hostility toward the analyst” (p. 113). For them the appearance of such aggression in the treatment represents a reaction to further narcissistic wounding due to a misunderstanding or misconstruction by the analyst. These self-psychologists emphasize the importance of analyzing innumerable and inevitable episodes of frustration and disappointment experienced by the patient as a failure on the part of the self-object analyst to fulfill a particular archaic wish or need.

As Kohut (1984) points out, a long period of simply understanding and communicating this understanding may be necessary before any form of deeper or genetic interpretation or explanation will have much of an effect. Patients with severe self-pathology must receive from the analyst the repeated experience of being understood many times over before they are able to remain sufficiently stable in the transference situation to utilize explanations

and interpretations. In my experience (1982, 1983a) it *is* possible over long periods of time with some borderline patients for such a gradual improvement in self-cohesion to occur. Much depends on the dedication of the therapist to the individual patient and the therapist's empathic capacities and willingness to endure a very long and difficult treatment.

A factor that has not received sufficient explicit consideration in the literature, but which shows itself strikingly in the case material of the followers of Kohut, is the vigorous and persistently tenacious dedication to these disturbed patients that appears in all the case material. As the therapist in Chapter 6 of the casebook writes:

> She experienced me as someone who would vigorously persist in an emotional involvement with her despite her tendency to detachment and retreat to quiet, defensive grandiosity or affective isolation. And as someone who would honestly recognize and respond to her growing sense of important inner value. All this effected a firming of her sense of wellbeing. (Goldberg 1978, p. 327)

It is hard to ignore the implication that this powerful investment in the patient has an important corrective experience similar to the early cases treated by Freud, whose dedication to his patients and

personal integrity form the model for us all (Chessick 1980).

Notes

1 “She wore out two records of Opus 130. She put it on tape so it would always be available” (p. 471). I had a similar patient who used Wagner’s entire *Ring of the Niebelung* (see Chessick 1983c for discussion of preoedipal elements of the *Ring)* for this purpose, playing it constantly and collecting every available recording—to the agonizing dismay of his roommates! For a related but failed experience, see the novel *An Evening of Brahms* (Sennett 1984).

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